United Nations A/HRC/35/21

General Assembly

Distr.: General
28 March 2017

Original: English

Human Rights Council
Thirty-fifth session
6-23 June 2017
Agenda item 3
Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Note by the secretariat

Pursuant to Human Rights Council resolution 24/6, the secretariat has the honour to transmit to the Council the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. In an attempt to contribute to the discussion around mental health as a global health priority, the Special Rapporteur focuses on the right of everyone to mental health and some of the core challenges and opportunities, urging that the promotion of mental health be addressed for all ages in all settings. He calls for a shift in the paradigm based on the recurrence of human rights violations in mental health settings, all too often affecting persons with intellectual, cognitive and psychosocial disabilities.

The Special Rapporteur makes a number of recommendations for States and all stakeholders to move towards mental health systems that are based on and compliant with human rights.

GE.17-04875(E)

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I. Introduction

1. Mental health and emotional well-being are priority areas of focus for the Special Rapporteur (see A/HRC/29/33). In each thematic report, he has attempted to bring mental health into focus as a human rights and development priority in the context of early childhood development (see A/70/213), adolescence (see A/HRC/32/32) and the Sustainable Development Goals (see A/71/304).

2. In the present report, the Special Rapporteur expands on this issue and provides a basic introduction to some of the core challenges and opportunities for advancing the realization of the right to mental health of everyone. In the light of the scope and complexity of the issue and of the evolving human rights framework and evidence base, in his report the Special Rapporteur seeks to make a contribution to the important discussions under way as mental health emerges from the shadows as a global health priority.

3. The present report is the result of extensive consultations among a wide range of stakeholders, including representatives of the disability community, users and former users of mental health services, civil society representatives, mental health practitioners, including representatives of the psychiatric community and the World Health Organization (WHO), academic experts, members of United Nations human rights mechanisms and representatives of Member States.

A note on terminology[1]

4. Everyone, throughout their lifetime, requires an environment that supports their mental health and well-being; in that connection, we are all potential users of mental health services. Many will experience occasional and short-lived psychosocial difficulties or distress that require additional support. Some have cognitive, intellectual and psychosocial disabilities, or are persons with autism who, regardless of self-identification or diagnosis, face barriers in the exercise of their rights on the basis of a real or perceived impairment and are therefore disproportionately exposed to human rights violations in mental health settings. Many may have a diagnosis related to mental health or identify with the term, while others may choose to identify themselves in other ways, including as survivors.

5. The present report distinguishes between users of services and persons with disabilities, based on the barriers faced by the latter, considering in an inclusive manner that everyone is a rights holder.

II. Context

6. Despite clear evidence that there can be no health without mental health, nowhere in the world does mental health enjoy parity with physical health in national policies and budgets or in medical education and practice. Globally, it is estimated that less than 7 per cent of health budgets is allocated to address mental health. In lower-income countries, less than $2 per person is spent annually on it.[2] Most investment is focused on long-term institutional care and psychiatric hospitals, resulting in a near total policy failure to promote mental health holistically for all.[3] The arbitrary division of physical and mental health and the subsequent isolation and abandonment of mental health has contributed to an untenable situation of unmet needs and human rights violations (see A/HRC/34/32, paras. 11-21), including of the right to the highest attainable standard of mental and physical health.[4]

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[1] See WHO, "Advocacy actions to promote human rights in mental health and related areas" (2017).

[2] WHO, Mental Health Atlas 2014, p. 9, and PLOS medicine editors, "The paradox of mental health: over-treatment and under-recognition", *PLOS Medicine*, vol. 10, No. 5 (May 2013).

[3] WHO, Mental Health Atlas 2014, p. 9.

[4] See also Human Rights Watch, "Living in hell: abuses against people with psychosocial disabilities in Indonesia" (March 2016).

7. Forgotten issues beget forgotten people. The history of psychiatry and mental health care is marked by egregious rights violations, such as lobotomy, performed in the name of medicine. Since the Second World War and the adoption of the Universal Declaration of Human Rights, together with other international conventions, increasing attention has been paid to human rights in global mental health and psychiatry. However, whether the global community has actually learned from the painful past remains an open question.

8. For decades, mental health services have been governed by a reductionist biomedical paradigm that has contributed to the exclusion, neglect, coercion and abuse of people with intellectual, cognitive and psychosocial disabilities, persons with autism and those who deviate from prevailing cultural, social and political norms. Notably, the political abuse of psychiatry remains an issue of serious concern. While mental health services are starved of resources, any scaled-up investment must be shaped by the experiences of the past to ensure that history does not repeat itself.

9. The modern understanding of mental health is shaped by paradigm shifts often marked by a combination of improvements and failures in evidence-based and ethical care. This began 200 years ago with the desire to unchain the "mad" in prison dungeons and moved to the introduction of psychotherapies, shock treatments, and psychotropic medications in the 20th century. The pendulum of how individual pathology is explained has swung between the extremes of a "brainless mind" and a "mindless brain". Recently, through the disability framework, the limitations of focusing on individual pathology alone have been acknowledged, locating disability and well-being in the broader terrain of personal, social, political, and economic lives.

10. Finding an equilibrium between the aforesaid extremes of the twentieth century has created a momentum for deinstitutionalization and the identification of a balanced, biopsychosocial model of care. Those efforts were reinforced by WHO in a report in 2001, in which it called for a modern public health framework and the liberation of mental health and those using mental health services from isolation, stigma and discrimination.[5] A growing research base has produced evidence indicating that the status quo, preoccupied with biomedical interventions, including psychotropic medications and non-consensual measures, is no longer defensible in the context of improving mental health. Most important have been the organized efforts of civil society, particularly movements led by users and former users of mental health services and organizations of persons with disabilities, in calling attention to the failures of traditional mental health services to meet their needs and secure their rights. They have challenged the drivers of human rights violations, developed alternative treatments and recrafted a new narrative for mental health.

11. The momentum sustained by civil society towards a paradigm shift has contributed to an evolving human rights framework in the area of mental health. The adoption of the Convention on the Rights of Persons with Disabilities in 2006 laid the foundation for that paradigm shift, with the aim of leaving behind the legacy of human rights violations in mental health services. The right to the highest attainable standard of health has much to contribute to advancing that shift and provides a framework for the full realization of the right of everyone to mental health.

12. One decade later, progress is slow. Effective, acceptable and scalable treatment alternatives remain on the periphery of health-care systems, deinstitutionalization has stalled, mental health investment continues to be predominantly focused on a biomedical model and mental health legislative reform has proliferated, undermining legal capacity and equal protection under the law for people with cognitive, intellectual and psychosocial disabilities. In some countries, the abandonment of asylums has created an insidious pipeline to homelessness, hospital and prison. When international assistance is available, it often supports the renovation of large residential institutions and psychiatric hospitals, undermining progress.

13. Public policies continue to neglect the importance of the preconditions of poor mental health, such as violence, disempowerment, social exclusion and isolation and the

[5] See WHO, *World Health Report 2001. Mental Health: New Understanding, New Hope*.

breakdown of communities, systemic socioeconomic disadvantage and harmful conditions at work and in schools. Approaches to mental health that ignore the social, economic and cultural environment are not just failing people with disabilities, they are failing to promote the mental health of many others at different stages of their lives.

14. With the adoption of the 2030 Agenda for Sustainable Development and recent efforts by influential global actors such as WHO, the Movement for Global Mental Health and the World Bank, mental health is emerging at the international level as a human development imperative. The 2030 Agenda and most of its sustainable development goals implicate mental health: Goal 3 seeks to ensure healthy lives and promote well-being at all ages and target 3.4 includes the promotion of mental health and well-being in reducing mortality from non-communicable diseases. How national efforts harness the momentum of the 2030 Agenda to address mental health has important implications for the effective realization of the right to health.

15. The current momentum and opportunity to advance are unique. It is from this juncture in history, within a confluence of international processes, that the Special Rapporteur seeks to make a contribution with the present report.

III. Global burden of obstacles

16. An effective tool used to elevate global mental health is the use of alarming statistics to indicate the scale and economic burden of "mental disorders". While it is uncontroversial to note that millions of people around the world are grossly underserved, the current "burden of disease" approach firmly roots the global mental health crisis within a biomedical model, too narrow to be proactive and responsive in addressing mental health issues at the national and global level. The focus on treating individual conditions inevitably leads to policy arrangements, systems and services that create narrow, ineffective and potentially harmful outcomes. It paves the way for further medicalization of global mental health, distracting policymakers from addressing the main risk and protective factors affecting mental health for everyone. To address the grossly unmet need for rights-based mental health services for all, an assessment of the "global burden of obstacles" that has maintained the status quo in mental health is required.

17. Three major obstacles which reinforce each other are identified in the following sections.

A. Dominance of the biomedical model

18. The biomedical model regards neurobiological aspects and processes as the explanation for mental conditions and the basis for interventions. It was believed that biomedical explanations, such as "chemical imbalance", would bring mental health closer to physical health and general medicine, gradually eliminating stigma.[6] However, that has not happened and many of the concepts supporting the biomedical model in mental health have failed to be confirmed by further research. Diagnostic tools, such as the International Classification of Diseases and the Diagnostic and Statistical Manual of Mental Disorders, continue to expand the parameters of individual diagnosis, often without a solid scientific basis.[7] Critics warn that the overexpansion of diagnostic categories encroaches upon human experience in a way that could lead to a narrowing acceptance of human diversity.[8]

19. However, the field of mental health continues to be over-medicalized and the reductionist biomedical model, with support from psychiatry and the pharmaceutical

[6] See Derek Bolton and Jonathan Hill, *Mind, Meaning and Mental Disorder: the Nature of Causal Explanation in Psychology and Psychiatry* (Oxford, Oxford University Press, 2004).

[7] See Thomas Insel, "Transforming diagnosis" (April 2013), available from www.nimh.nih.gov/about/director/2013/transforming-diagnosis.shtml.

[8] See Stefan Priebe, Tom Burns and Tom K.sJ. Craig, "The future of academic psychiatry may be social", *British Journal of Psychiatry*, vol. 202, No. 5 (May 2013).

industry, dominates clinical practice, policy, research agendas, medical education and investment in mental health around the world. The majority of mental health investments in low-, middle- and high-income countries disproportionately fund services based on the biomedical model of psychiatry.[9] There is also a bias towards first-line treatment with psychotropic medications, in spite of accumulating evidence that they are not as effective as previously thought, that they produce harmful side effects and, in the case of antidepressants, specifically for mild and moderate depression, the benefit experienced can be attributed to a placebo effect.[10] Despite those risks, psychotropic medications are increasingly being used in high-, middle- and low-income countries across the world.[11] We have been sold a myth that the best solutions for addressing mental health challenges are medications and other biomedical interventions.

20. The psychosocial model has emerged as an evidence-based response to the biomedical paradigm.[12] It looks beyond (without excluding) biological factors, understanding psychological and social experiences as risk factors contributing to poor mental health and as positive contributors to well-being. That can include short-term and low-cost interventions that can be integrated into regular care. When used appropriately, such interventions can empower the disadvantaged, improve parenting and other competencies, target individuals in their context, improve the quality of relationships and promote self-esteem and dignity. For any mental health system to be compliant with the right to health, the biomedical and psychosocial models and interventions must be appropriately balanced, avoiding the arbitrary assumption that biomedical interventions are more effective.[13]

B. Power asymmetries

21. The promotion and protection of human rights in mental health is reliant upon a redistribution of power in the clinical, research and public policy settings. Decision-making power in mental health is concentrated in the hands of biomedical gatekeepers, in particular biological psychiatry backed by the pharmaceutical industry. That undermines modern principles of holistic care, governance for mental health, innovative and independent interdisciplinary research and the formulation of rights-based priorities in mental health policy. International organizations, specifically WHO and the World Bank, are also influential stakeholders, whose role and relations interplay and overlap with the role of the psychiatric profession and the pharmaceutical industry.

22. At the clinical level, power imbalances reinforce paternalism and even patriarchal approaches, which dominate the relationship between psychiatric professionals and users of mental health services. That asymmetry disempowers users and undermines their right to make decisions about their health, creating an environment where human rights violations can and do occur. Laws allowing the psychiatric profession to treat and confine by force legitimize that power and its misuse. That misuse of power asymmetries thrives, in part, because legal statutes often compel the profession and obligate the State to take coercive action.

23. The professional group in psychiatry is a powerful actor in mental health governance and advocacy. National mental health strategies tend to reflect biomedical agendas and obscure the views and meaningful participation of civil society, users and former users of

[9] See WHO, Mental Health Atlas 2014, p. 32.

[10] See Irving Kirsch, "Antidepressants and the placebo effect", *Zeitschrift für Psychologie*", vol. 222, No. 3 (February 2015) and David Healy, "Did regulators fail over selective serotonin reuptake inhibitors?", *BMJ*, vol. 333 (July 2006).

[11] See Ross White, "The globalisation of mental illness", *The Psychologist*, vol. 26 (March 2013).

[12] See Anne Cooke, ed., *Understanding Psychosis and Schizophrenia*, (Leicester, The British Psychological Society, 2014).

[13] See Nikolas Rose and Joelle M. Abi-Rached, *Neuro: the New Brain Sciences and the Management of the Mind* (Princeton, New Jersey, Princeton University Press, 2013) and Pat Bracken, "Towards a hermeneutic shift in psychiatry", *World Psychiatry*, vol. 13, No. 3 (October 2014).

mental health services and experts from various non-medical disciplines.[14] In that context, the 2005 *WHO Resource Book on Mental Health, Human Rights and Legislation*, developed using human rights guidelines at the time, was highly influential in the development of mental health laws that allowed "exceptions". Those legal "exceptions" normalized coercion in everyday practice, widening the space for human rights violations to occur and it is therefore a welcome development to see the laws being revisited and the *Resource Book* formally withdrawn, as a result of the framework brought about by the Convention on the Rights of Persons with Disabilities.[15]

24. The status quo in current psychiatry, based on power asymmetries, leads to the mistrust of many users and threatens and undermines the reputation of the psychiatric profession. Open and ongoing discussions within the psychiatric profession about its future, including its role in relation to other stakeholders, is critical.[16] The Special Rapporteur welcomes and encourages such discussions within the psychiatric profession and with other stakeholders, and he is convinced that the search for consensus and progress is to the advantage of everyone, including psychiatry. The active involvement of the psychiatric profession and its leaders in the shift towards rights-compliant mental health policies and services is a crucial element for success in positive global mental health changes.

25. Conventional wisdom based on a reductionist biomedical interpretation of complex mental health-related issues dominates mental health policies and services, even when not supported by research. Persons with psychosocial disabilities continue to be falsely viewed as dangerous, despite clear evidence that they are commonly victims rather than perpetrators of violence.[17] Likewise, their capacity to make decisions is questioned, with many being labelled incompetent and denied the right to make decisions for themselves. That stereotype is now regularly shattered, as people show that they can live independently when empowered through appropriate legal protection and support.

26. Asymmetries have been furthered by the financial power of, and alliances with, the pharmaceutical industry. Where financial resources for research and innovation are absent, the industry fills the gap with little transparency in drug approval processes or in doubtful relationships with health-care professionals and providers. That context illustrates how overreliance in policy on the biomedical model has gone too far and is now so resistant to change.[18]

C. Biased use of evidence in mental health

27. The evidence base in support of mental health interventions has been problematic throughout history. That situation continues, as the evidence base for the efficacy of certain psychotropic medications and other biomedical psychiatric interventions is increasingly challenged from both a scientific and experiential perspective.[19] That these interventions

[14] See the WHO MiNDbank, available from www.mindbank.info/collection/type/mental_health_strategies_and_plans/all.

[15] See www.who.int/mental_health/policy/legislation/en/.

[16] See Heinz Katschnig, "Are psychiatrists an endangered species? Observations on internal and external challenges to the profession", *World Psychiatry*, vol. 9, No. 1 (February 2010).

[17] See Jillian K. Peterson and others, "How often and how consistently do symptoms directly precede criminal behavior among offenders with mental illness?", *Law and Human Behavior*, vol. 38, No. 5 (April 2014).

[18] See Ray Moynihan, Jenny Doust and David Henry, "Preventing overdiagnosis: how to stop harming the healthy", *BMJ*, vol. 344 (May 2012).

[19] See Peter Tyrer and Tim Kendall, "The spurious advance of antipsychotic drug therapy", *The Lancet*, vol., No. 9657 (January 2009); Lex Wunderink and others, "Recovery in remitted first-episode psychosis at 7 years of follow-up of an early dose reduction/discontinuation or maintenance treatment strategy", *JAMA Psychiatry*, vol. 70, No. 9 (2013); Joanna Le Noury and others, "Restoring Study 329: efficacy and harms of paroxetine and imipramine in treatment of major depression in adolescence", *BMJ*, vol. 351 (September 2015); and Andrea Cipriani and others, "Comparative efficacy and tolerability of antidepressants for major depressive disorder in children and adolescents: a network meta-analysis", *The Lancet*, vol., 388, No. 10047 (August 2016).

can be effective in managing certain conditions is not disputed, but there are increasing concerns about their overprescription and overuse in cases where they are not needed.[20] There is a long history of pharmaceutical companies not disclosing negative results of drug trials, which has obscured the evidence base for their use. That denies health professionals and users access to the information necessary for making informed decisions.[21]

28. Powerful actors influence the research domain, which shapes policy and the implementation of evidence. Scientific research in mental health and policy continues to suffer from a lack of diversified funding and remains focused on the neurobiological model. In particular, academic psychiatry has outsize influence, informing policymakers on resource allocation and guiding principles for mental health policies and services. Academic psychiatry has mostly confined its research agenda to the biological determinants of mental health. That bias also dominates the teaching in medical schools, restricting the knowledge transfer to the next generation of professionals and depriving them of an understanding of the range of factors that affect mental health and contribute to recovery.

29. Because of biomedical bias, there exists a worrying lag between emerging evidence and how it is used to inform policy development and practice. For decades now, an evidence base informed by experiential and scientific research has been accumulating in support of psychosocial, recovery-oriented services and support and non-coercive alternatives to existing services. Without promotion of and investment in such services and the stakeholders behind them, they will remain peripheral and will not be able to generate the changes they promise to bring.

IV. Evolving normative framework for mental health

30. The Constitution of WHO defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Like all aspects of health, a range of biological, social and psychological factors affect mental health.[22] It is from this understanding that duty bearers can more accurately understand their corresponding obligations to respect, protect and fulfil the right to mental health for all. Most of the current discussions around mental health and human rights have focused on informed consent in the context of psychiatric treatment. While that discourse is deeply meaningful, it has emerged as a result of systemic failures to protect the right to mental health and to provide non-coercive treatment alternatives.

31. The evolving normative context around mental health involves the intimate connection between the right to health, with the entitlement to underlying determinants, and the freedom to control one's own health and body. That is also linked to the right to liberty, freedom from non-consensual interference and respect for legal capacity. While informed consent is needed to receive treatment that is compliant with the right to health, legal capacity is needed to provide consent and must be distinguished from mental capacity. The right to health also includes a right to integration and treatment in the community with appropriate support to both live independently and to exercise legal capacity (see, for example, E/CN.4/2005/51, paras. 83-86, and A/64/272, para. 10).[23] The denial of legal capacity frequently leads to deprivation of liberty and forced medical interventions, which raises questions not only about the prohibition of arbitrary detention and cruel, inhuman or degrading treatment, but also the right to health.

32. Prior to the adoption of the Convention on the Rights of Persons with Disabilities, various non-binding instruments guided States in identifying their obligations to protect the rights of persons with disabilities in the context of treatment (see General Assembly resolutions 37/53, 46/119 and 48/96). While some of them recognized important rights and

[20] See Ray Moynihan, "Preventing overdiagnosis: how to stop harming the healthy".

[21] See Irving Kirsch and others, "Initial severity and antidepressant benefits: a meta-analysis of data submitted to the Food and Drug Administration", *PLOS Medicine* (February 2008).

[22] See WHO, Mental Health Action Plan 2013-2020 (2013), p. 7.

[23] See also Committee on the Rights of Persons with Disabilities, general comment No. 1 (2014) on equal recognition before the law, para. 13.

standards, the safeguards they contained were often rendered meaningless in everyday practice (see E/CN.4/2005/51, paras. 88-90, and A/58/181). As the right to health guarantees freedom from discrimination, involuntary treatment and confinement, it must also be understood to guarantee the entitlement to treatment and integration in the community. The failure to secure that entitlement and other freedoms is a primary driver of coercion and confinement.

33. The Committee on the Rights of Persons with Disabilities emphasizes full respect for legal capacity, the absolute prohibition of involuntary detention based on impairment and the elimination of forced treatment (see A/HRC/34/32, paras. 22-33).[24] That responds to the inadequacy of procedural safeguards alone, requiring sharpened attention to non-coercive alternatives and community inclusion to secure the rights of persons with disabilities. Within that evolving framework, not all human rights mechanisms have embraced the absolute ban on involuntary detention and treatment articulated by the Committee. They include the Subcommittee on the Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (see CAT/OP/27/2), the Committee Against Torture[25] and the Human Rights Committee.[26] However, their interpretation of exceptions used to justify coercion is narrower, signalling ongoing discussions on the matter. Notably, in the United Nations Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of Their Liberty to Bring Proceedings Before a Court, the Working Group on Arbitrary Detention supported the provisions of the Convention on the Rights of Persons with Disabilities with regard to safeguards on the prohibition of arbitrary detention (see A/HRC/30/37, paras. 103-107).

34. At present, there is an impasse over how obligations in relation to non-consensual treatment are implemented in the light of the provisions of the Convention on the Rights of Persons with Disabilities, given the different interpretation by international human rights mechanisms. The Special Rapporteur has followed these developments and hopes that consensus can be reached to start the shift towards strengthened mental health policies and services without delay. He seeks to participate actively in these processes and potentially report again on the progress achieved.

V. Right to mental health framework

A. Obligations

35. The International Covenant on Economic, Social and Cultural Rights provides a legally binding framework for the right to the highest attainable standard of mental health. That is complemented by legal standards established, among others, by the Convention on the Rights of Persons with Disabilities, the Convention for the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child. States parties have an obligation to respect, protect and fulfil the right to mental health in national laws, regulations, policies, budgetary measures, programmes and other initiatives.

36. The right to mental health includes both immediate obligations and requirements to take deliberate, concrete, targeted action to progressively realize other obligations.[27] States must use appropriate indicators and benchmarks to monitor progress, including in respect of reducing and eliminating medical coercion. Indicators should be disaggregated by, among others, sex, age, race and ethnicity, disability and socioeconomic status. States must devote the maximum available resources to the right to health, yet globally, spending on mental health stands at less than 10 per cent of spending on physical health.

[24] See also Convention on the Rights of Persons with Disabilities, arts. 12 and14, Committee on the Rights of Persons with Disabilities, general comment No. 1 and guidelines on article 14 of the Convention.

[25] See CAT/C/FIN/CO/7, paras. 22-23; CAT/C/FRA/CO/7, paras. 29-30; CAT/C/AZE/CO/4, paras. 26-27; and CAT/C/DNK/CO/6-7, paras. 40-41.

[26] See general comment No. 35 (2014) on liberty and security of person.

[27] International Covenant on Economic, Social and Cultural Rights, art. 2 (1).

37. Some obligations are not subject to progressive realization and must be implemented immediately, including certain freedoms and core obligations. Core obligations include the elaboration of a national public health strategy and non-discriminatory access to services.[28] In terms of the right to mental health, that translates into the development of a national mental health strategy with a road map leading away from coercive treatment and towards equal access to rights-based mental health services, including the equitable distribution of services in the community.

B. International cooperation

38. International treaties recognize the obligation of international cooperation for the right to health, a responsibility reinforced by the commitment to a global partnership for sustainable development in Sustainable Development Goal 17. Higher-income States have a particular duty to provide assistance for the right to health, including mental health, in lower-income countries. There is an immediate obligation to refrain from providing development cooperation supporting mental health-care systems that are discriminatory or where violence, torture and other human rights violations occur. Rights-based development cooperation should support balanced health promotion and psychosocial interventions and other treatment alternatives, delivered in the community to effectively safeguard individuals from discriminatory, arbitrary, excessive, inappropriate and/or ineffective clinical care.

39. In view of that obligation, it is troubling that mental health is still neglected in development cooperation and other international policies on health financing. Between 2007 and 2013, only 1 per cent of international health aid went to mental health.[29] In times of humanitarian crises, in both the relief and recovery stages, international support must include psychosocial support to strengthen resilience in the face of enormous adversity and suffering. Elsewhere, where cooperation has been provided, it has prioritized the improvement of existing psychiatric hospitals and long-term care facilities that are inherently incompatible with human rights.[30]

40. International assistance and cooperation also includes technical support for rights-based mental health policies and practices. The WHO QualityRights initiative is a commendable example of such technical assistance. The Special Rapporteur also welcomes recent support by the World Bank and WHO for moving mental health to the centre of the global development agenda. However, he cautions that such global initiatives must incorporate the full range of human rights. In particular, multilateral agencies should give priority to ensuring the attainment of the right to health of those in the most vulnerable situations, such as persons with disabilities. A global agenda that focuses on anxiety and depression (common mental health conditions) may reflect a failure to include the persons most in need of rights-based changes in mental health services. Such selective agendas can reinforce practices based on the medicalization of human responses and inadequately address structural issues, such as poverty, inequality, gender stereotypes and violence.

41. States have an obligation to protect against harm by third parties, including the private sector, and should work to ensure that private actors support the realization of the right to mental health, while fully understanding their role and duties in that respect.

C. Participation

42. The effective realization of the right to health requires the participation of everyone, particularly those living in poverty and in vulnerable situations, in decision-making at the legal, policy, community and health service level. At the population level, empowering everyone to participate meaningfully in decisions about their health and well-being requires

[28] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000) on the right to the highest attainable standard of health, paras. 43-45.

[29] Seth Mnookin, "Out of the shadows: making mental health a global development priority", World Bank Group and WHO (2016), p.13.

[30] Committee on Economic, Social and Cultural Rights, general comment No. 5, para. 15.

multisectoral and inclusive engagement with stakeholders, such as users and former users of mental health services, policymakers, service providers, health workers, social workers, the legal profession, the police, carers, family members and the wider community.

43. Health settings must empower users as rights holders to exercise autonomy and participate meaningfully and actively in all matters concerning them, to make their own choices about their health, including sexual and reproductive health, and their treatment, with appropriate support where needed.

44. Participation in mental health services is a relatively recent phenomenon and is complicated by deeply entrenched power asymmetries within mental health systems.[31] It is important to facilitate the empowerment of individuals, especially those with particular mental health needs, through the support of self-advocacy initiatives, peer support networks, trialogues and other user-led advocacy initiatives, as well as new working methods, such as co-production, which ensure representative and meaningful participation in health-service development and provision. In that regard, creating space for civil society and supporting the activities of non-governmental organizations is crucial to restoring trust between care providers and rights holders using services.

D. Non-discrimination

45. International human rights law guarantees the right to non-discrimination in the access to and delivery of mental health-care services and the underlying determinants of health.[32] The right to mental health is also dependent on equality and non-discrimination in the enjoyment of all other human rights that can themselves be considered an underlying determinant.[33]

46. Multiple and intersectional forms of discrimination continue to impede the ability of individuals, including women and persons from racial and ethnic minorities with disabilities, to realize their right to mental health. Discrimination and inequality are both a cause and a consequence of poor mental health, with long-term implications for morbidity, mortality and societal well-being.[34] Discrimination, harmful stereotypes (including gender) and stigma in the community, family, schools and workplace disable healthy relationships, social connections and the supportive and inclusive environments that are required for the good mental health and well-being of everyone. Likewise, discriminatory attitudes influencing policies, laws and practices constitute barriers for those requiring emotional and social support and/or treatment. Consequently, individuals and groups in vulnerable situations who are discriminated against by law and/or in practice are denied their right to mental health.

47. Discrimination, de jure and de facto, continues to influence mental health services, depriving users of a variety of rights, including the rights to refuse treatment, to legal capacity and to privacy, and other civil and political rights. The role of psychiatry and other mental health professions is particularly important and measures are needed to ensure that their professional practices do not perpetuate stigma and discrimination.

48. It is important to recognize the complex role that a diagnosis of mental disorder plays in people's lives. While many people find diagnostic categories beneficial in allowing them to access services and better understand their mental health, others find them unhelpful and stigmatizing. Mental health diagnoses have been misused to pathologize identities and other diversities, including tendencies to medicalize human misery. The

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[31] See Judi Chamberlin, "User/consumer involvement in mental health service delivery", *Epidemiology and Psychiatric* Sciences, vol. 14, No. 1 (March 2005).

[32] Committee on Economic, Social and Cultural Rights, general comment No. 14, para. 18; A/61/338, para. 18 and Convention on the Rights of Persons with Disabilities, arts. 25 and 26.

[33] See Committee on Economic, Social and Cultural Rights, general comment No. 20 (2009) on non-discrimination in economic, social and cultural rights.

[34] See Kate Pickett and Richard Wilkinson, *The Spirit Level: Why More Equal Societies Almost Always Do Better*, (London, Penguin Books, 2010).

pathologization of lesbian, gay, bisexual, transgender and intersex persons reduces their identities to diseases, which compounds stigma and discrimination.

49. The problem is not in diagnosing persons but in the discriminatory practices that affect the diagnosed person, which may cause more harm than the diagnosis itself. People frequently suffer more from discriminatory and inappropriate patterns of "care" than from the natural effects of mental health conditions.

50. Diversity must be broadly understood, recognizing the diversity of human experience and the variety of ways in which people process and experience life. Respecting that diversity is crucial to ending discrimination. Peer-led movements and self-help groups, which help to normalize human experiences that are considered unconventional, contribute towards more tolerant, peaceful and just societies.

E. Accountability

51. Accountability for the enjoyment of the right to mental health depends on three elements: (a) monitoring; (b) independent and non-independent review, such as by judicial, quasi-judicial, political and administrative bodies, as well as by social accountability mechanisms; and (c) remedies and redress. Accountability provides an opportunity for rights holders to understand how duty bearers have discharged their duties and claim redress where rights are violated. It also provides an opportunity for duty bearers to explain their actions and make amendments if required.

52. At the international level, the adoption of the Convention on the Rights of Persons with Disabilities and the relevant State party reporting processes provide an important new avenue for accountability for the right to mental health of persons with psychosocial, cognitive and intellectual disabilities. By contrast, at the national level, accountability mechanisms for the right to mental health are often not fit for purpose. Of particular concern is the growing prevalence of mental health tribunals, which instead of providing a mechanism for accountability, legitimize coercion and further isolate people within mental health systems from access to justice. Despite commendable efforts by several national prevention mechanisms, human rights violations in mental health services are rife and occur with impunity.[35] Individuals often have limited access to justice, including independent accountability mechanisms. That may arise because they are deemed to lack legal capacity and have limited knowledge of their rights, legal aid cannot be accessed, or simply because oversight of complaints bodies does not exist.

53. The Convention establishes that all mental health services designed for persons with disabilities are to be effectively monitored by independent authorities (art. 16.3). Human rights must be incorporated into the framework of reference for all monitoring and review procedures in the field of mental health. The Special Rapporteur encourages national human rights institutions to pay attention to the right to mental health in their monitoring and promotion activities. Persons with lived experience, their families and civil society should be engaged in the development and implementation of monitoring and accountability arrangements.

F. Beyond mental health services towards care and support

54. The right to mental health requires care and support facilities, goods and services that are available, accessible, acceptable and of good quality. Rights-based care and support for mental health is an integral part of health care for all.

[35] See Association for the Prevention of Torture, "Monitoring psychiatric institutions" Jean-Jacques Gautier NPM symposium outcome report (2016), available from www.apt.ch/content/files_res/report-jjg-symposium-2016-en.pdf.

Availability

55. Adequate mental health services must be made available. In many countries, the limited mental health and social care available is based on a narrow biomedical model and institutionalization. The scaling-up of care must not involve the scaling-up of inappropriate care. For care to comply with the right to health, it must embrace a broad package of integrated and coordinated services for promotion, prevention, treatment, rehabilitation, care and recovery and the rhetoric of "scaling up" must be replaced with mental health actions to "scale across". That includes mental health services integrated into primary and general health care, which support early identification and intervention, with services designed to support a diverse community.[36] Evidence-based psychosocial interventions and trained community health workers to deliver them must be enhanced.[37] Services must support the rights of people with intellectual, cognitive and psychosocial disabilities and with autism to live independently and be included in the community, rather than being segregated in inappropriate care facilities.

56. Many countries are faced with a scarcity of human resources for mental health care and must undertake efforts to develop a workforce, including specialist and non-specialist health professionals, general practitioners and community health workers, as well as other professionals, such as teachers, social workers and other peer support and community workers with appropriate skills (including human rights education).

Accessibility

57. Mental health services must be geographically and financially accessible on the basis of non-discrimination. In many low- and middle-income countries they are concentrated in major cities and inaccessible to a large part of the population. The problem is acute in countries where there is inappropriate overreliance on segregated residential and in-patient psychiatric institutions, such as in Central and Eastern Europe, and a failure to develop rights-based models of care in the community.[38] Integrating mental health into general hospitals, primary care, and social care services and rights-compliant use of mobile technologies can support accessibility and enhance the enjoyment of the right to live and participate in the community. Accurate information on mental health must be made accessible to the public and evidence-based information on treatments, including side effects, must also be accessible, which requires the routine, complete and timely disclosure of all pharmacological information from clinical trials. A contextual understanding of the experiences of suffering and distress is critical for ensuring accessibility within systems of mental health care and support.

Acceptability

58. Mental health services must be respectful of medical ethics and human rights, as well as culturally appropriate, sensitive to gender and life-cycle requirements and designed to respect confidentiality and empower individuals to control their health and well-being.[39] They must respect the principles of medical ethics and human rights (including "first, do no harm"), choice, control, autonomy, will, preference and dignity.[40] Overreliance on pharmacological interventions, coercive approaches and in-patient treatment is inconsistent with the principle of doing no harm, as well as with human rights. Human rights capacity-building should be routinely provided to mental health professionals. Services must be culturally appropriate and acceptable to persons with intellectual, cognitive or psychosocial disabilities and with autism, adolescents, women, older persons, indigenous persons, minorities, refugees and migrants, and lesbian, gay, bisexual, transgender and intersex

[36] Convention on the Rights of Persons with Disabilities, arts. 25-26, and J. Jaime Miranda and others, "Transitioning mental health into primary care", *The Lancet Psychiatry*, vol. 4, No. 2 (February 2017).

[37] WHO, Mental Health Action Plan 2013-2020, p. 9.

[38] Natalie Drew and others, "Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis", *The Lancet*, vol. 378, No. 9803 (November 2011).

[39] Committee on Economic, Social and Cultural Rights, general comment No. 14, para. 12 (c).

[40] Convention on the Rights of Persons with Disabilities, preamble and arts. 12, 15 and 19.

persons. Many within those populations are needlessly medicalized and suffer from coercive practices, based on inappropriate and harmful gender stereotypes.

59. Special attention should be paid to women, who suffer disproportionately from mental health practices that are based on paternalistic and patriarchal traditions, inappropriate and harmful gender stereotypes, medicalization of women's feelings and behaviour, and coercion. Women who have suffered from violence and inequalities within their families, communities and societies, and who have mental health conditions very often face situations in mental health settings that amount to violence, coercion, humiliation and disrespect for their dignity. It is unacceptable that after suffering from violations in family and other settings, women suffer from violations again within services that are supposed to promote their mental health. In that regard, it is very important to emphasize that violations of sexual and reproductive health rights have a direct, negative impact on the mental health of women.

Quality

60. Mental health services must be of good quality. That requires the use of evidence-based practices to support prevention, promotion, treatment and recovery.[46] Effective collaboration between different service providers and people using the services and their families and care partners, also supports enhanced quality of care. The abuse of biomedical interventions, including the inappropriate use or overprescription of psychotropic medications and the use of coercion and forced admissions, compromise the right to quality care. Prioritizing the scaling-up of community-based psychosocial services and mobilizing social resources that can support everyone throughout their life course, will enhance the quality of services.

61. The element of quality compels going beyond the idea of users as mere recipients of care towards their full consideration as active holders of rights. To stop discriminatory practices, States should rethink the way they provide mental health care and support (see A/HRC/34/58).

62. In particular, children and adults with intellectual disabilities and with autism too often suffer from institutionalized approaches and excessively medicalized practices. Institutionalizing and medicating children with autism, based on their impairment, is unacceptable. Autism represents a critical challenge to modern systems of care and support, as medical attempts to "cure" the condition have often turned out to be harmful, leading to further mental health deterioration of children and adults with the condition. Support for them should not only address their right to health, but their rights to education, employment and living in the community on an equal basis with others.

G. Informed consent and coercion

63. Informed consent is a core element of the right to health, both as a freedom and an integral safeguard to its enjoyment (see A/64/272). The right to provide consent to treatment and hospitalization includes the right to refuse treatment (see E/CN.4/2006/120, para. 82). The proliferation of paternalistic mental health legislation and lack of alternatives has made medical coercion commonplace.

64. Justification for using coercion is generally based on "medical necessity" and "dangerousness". These subjective principles are not supported by research and their application is open to broad interpretation, raising questions of arbitrariness that has come under increasing legal scrutiny. "Dangerousness" is often based on inappropriate prejudice, rather than evidence. There also exist compelling arguments that forced treatment, including with psychotropic medications, is not effective, despite its widespread use.[47]

[46] WHO Mental Health Action Plan 2013-2020, p. 9.

[47] See Steve R. Kisely and Leslie A. Campbell, "Compulsory community and involuntary outpatient treatment for people with severe mental disorders", Cochrane database system (December 2014); and

Decisions to use coercion are exclusive to psychiatrists, who work in systems that lack the clinical tools to try non-coercive options. The reality in many countries is that alternatives do not exist and reliance on the use of coercion is the result of a systemic failure to protect the rights of individuals.

65. Coercion in psychiatry perpetuates power imbalances in care relationships, causes mistrust, exacerbates stigma and discrimination and has made many turn away, fearful of seeking help within mainstream mental health services. Considering that the right to health is now understood within the framework of the Convention on the Rights of Persons with Disabilities, immediate action is required to radically reduce medical coercion and facilitate the move towards an end to all forced psychiatric treatment and confinement. In that connection, States must not permit substitute decision-makers to provide consent on behalf of persons with disabilities on decisions that concern their physical or mental integrity; instead, support should be provided at all times for them to make decisions, including in emergency and crisis situations.[45]

66. The Special Rapporteur takes note of the concerns of various stakeholders, particularly within the medical communities, regarding the absolute ban on all forms of non-consensual measures.[46] He acknowledges that their radical reduction and eventual elimination is a challenging process that will take time. However, there is shared agreement about the unacceptably high prevalence of human rights violations within mental health settings and that change is necessary. Instead of using legal or ethical arguments to justify the status quo, concerted efforts are needed to abandon it. Failure to take immediate measures towards such a change is no longer acceptable and the Special Rapporteur proposes five deliberate, targeted, and concrete actions as follows:

(a) Mainstream alternatives to coercion in policy with a view to legal reform;

(b) Develop a well-stocked basket of non-coercive alternatives in practice;

(c) Develop a road map to radically reduce coercive medical practices, with a view to their elimination, with the participation of diverse stakeholders, including rights holders;

(d) Establish an exchange of good practices between and within countries;

(e) Scale up research investment and quantitative and qualitative data collection to monitor progress towards these goals.

II. Underlying and social determinants of mental health

67. The right to health is an inclusive right to both health care and the underlying and social determinants of health. Public health has individual and collective dimensions, which are essential in securing the right to the enjoyment of the underlying and social determinants of health.[47] Given the deep connections between mental health and the physical, psychosocial, political and economic environment, the right to determinants of health is a precondition for securing the right to mental health. Under international human rights law, States must act on a range of underlying determinants, such as violence, supportive family environments and discrimination, to secure in particular the right to health of children and women[48] and persons with disabilities.[49] In short, respecting,

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[45] Hans Joachim Salize and Harald Dressing, "Coercion, involuntary treatment and quality of mental health care: is there any link?", *Current Opinion in Psychiatry*, vol. 18, No. 5 (October 2005).

[46] Guidelines on article 14 of the Convention, para. 22.

[47] See Melvyn C. Freeman and others, "Reversing hard-won victories in the name of human rights: a critique of the general comment on article 12 of the UN Convention on the Rights of Persons with Disabilities" *The Lancet Psychiatry*, vol. 2, No. 9 (September 2015).

[48] International Covenant on Economic, Social and Cultural Rights, art. 12 (2), and Committee on Economic, Social and Cultural Rights, general comment No. 14, para. 37.

[49] Convention on the Rights of the Child, art. 24, and Convention on the Elimination of All Forms of Discrimination against Women, art. 12.

[50] Convention on the Rights of Persons with Disabilities, art. 25 (a) and (b).

protecting and fulfilling the right to mental health requires concerted action to secure certain preconditions that are associated with mental health.

68. Various international and regional processes have helped to define the public health and social justice imperatives for addressing the social determinants of health. The final report of the Commission on Social Determinants of Health was a pioneering piece that brought greater visibility to social determinants.[48] Medicine, in particular its mental health component, is to a large extent a social science and this understanding should be used to guide its practice. To take full account of the evidence around the determinants of mental health, the right to those determinants must expand beyond inequities, discrimination and the physical environment to reflect the documented importance of healthy psychosocial environments (see A/70/213 para. 55 and A/71/304, paras. 16 and 19).[49] That includes developing public policies that promote non-violent and respectful relationships in families, schools, workplaces, communities and health and social services.

VI. Shifting the paradigm

A. The human rights imperative to address promotion and prevention in mental health

69. The recognition by WHO of the importance of developing rights-based strategies, which promote and protect the mental health of entire populations, is welcomed.[50] Individual and social factors, cultural values and the social experiences of everyday life in families, schools, the workplace and communities influence the mental health of each person. The fact that children spend a significant amount of time in schools and most adults at the workplace, means that rights-based action must promote healthy, safe and enabling environments that are free from violence, discrimination and other forms of abuse. Likewise, a person's mental health affects life within those domains and is integral to shaping the health of communities and populations. Population-based approaches to mental health promotion move health systems beyond individualized responses towards action on a range of structural barriers and inequalities (social determinants) that can negatively affect mental health.

70. There exists an almost universal commitment to pay for hospitals, beds and medications instead of building a society in which everyone can thrive. Regrettably, prevention and promotion are forgotten components of mental health action. Harmful assumptions that goodwill and sacrifice alone will enable populations to achieve mental health and well-being have excused this inaction.

71. The obligation to secure social determinants to promote mental health requires cross-sectoral action to ensure a robust commitment from all relevant ministries. For example, suicide prevention strategies are traditionally targeted towards high-risk groups and address clinical depression as a biomedical phenomenon, while cross-sectoral programmes that address the social and environmental determinants of suicide through population-based approaches show more promise. Bullying in schools is another phenomenon to be considered as a global and national public health priority. States should first and foremost address emotional and psychosocial environments, targeting relationships rather than individuals.

72. An environment that respects, protects and fulfils human rights and is free from all forms of violence, including gender-based violence, is fundamental for effective health promotion. Public health and psychosocial interventions are essential components of a

[48] *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health* (Geneva, WHO, 2008).

[49] See also WHO, "Investing in mental health: evidence for action" (2013) and "Risks to mental health: an overview of vulnerabilities and risk factors", discussion paper (2012).

[50] WHO Mental Health Action Plan 2013-2020.

rights-based mental health system, not a luxury. Relevant action must be based upon empowerment so as to enable individuals to increase control over and improve their health.

Adversity in early childhood and adolescence

73. Research has shown the damaging mental health and social impact of adversities and trauma experienced throughout childhood.[51] Toxic stress, abusive family and intimate relationships, the placement of young children in institutional care, bullying, sexual, physical and emotional child abuse and parental loss negatively affect brain development and the ability to form healthy relationships, all affecting the ability of children to fully realize their right to health as they transition into adulthood (see A/HRC/32/32, paras. 67-73, and A/70/213, para. 67).

74. The Special Rapporteur highlights the devastating impact that institutionalization has on young children, particularly on their mental health and holistic development.[52] Mental health-related services for children receive inadequate investment and lack quality standards of care and staffing, thus creating an environment where abuse is common for children with disabilities or with difficulties in social and emotional development, especially for those in institutional care. There are many examples of innovative child mental health services and practices throughout the world and there is convincing research on their effectiveness in promoting mental health and preventing deterioration in mental health conditions.[53] However, those good practices often serve merely as pilot projects, owing to a lack of political will to replicate and mainstream them in general childcare services.

75. Considering that mental health services are often underfunded, the resulting low-quality residential and in-patient psychiatric services lead to over-medicalization, violence and other forms of violations of children's rights. These must be abandoned or substantially transformed and more importantly, programmes to respond to childhood adversity must be organized around participatory frameworks that recognize children as rights holders, respect their evolving capacities and empower children and families to improve their mental health and well-being.

B. Treatment: from isolation to community

76. The right to health is a powerful guide for States towards a paradigm shift that is recovery and community-based, promotes social inclusion and offers a range of rights-based treatments and psychosocial support at primary and specialized care levels.

77. Reductive biomedical approaches to treatment that do not adequately address contexts and relationships can no longer be considered compliant with the right to health. While a biomedical component remains important, its dominance has become counter-productive, disempowering rights holders and reinforcing stigma and exclusion. In many parts of the world, community care is not available, accessible, acceptable and/or of sufficient quality (often limited to psychotropic medications). The largest concentration of mental hospitals and beds separated from regular health care is in higher-income countries, a cautionary note for lower and middle-income countries to forge a different path and shift to rights-based mental health care.[54]

[51] See Department of Economic and Social Affairs, "Mental health matters: social inclusion of youth with mental health conditions" (2014).

[52] See WHO and the Gulbenkian Global Mental Health Platform, "Promoting rights and community living for children with psychosocial disabilities" (2015) and United Nations Children's Fund, "Ending the placement of children under three in institutions: support nurturing families for all young children" (2012).

[53] International Association for Child and Adolescent Psychiatry and Allied Professions, "Textbook of child and adolescent mental health" (2015).

[54] WHO Mental Health Atlas 2014, table 4.1.1.

Mainstreaming mental health

78. The right to health requires that mental health care be brought closer to primary care and general medicine, integrating mental with physical health, professionally, politically and geographically. It not only integrates mental health services into mainstream health care so they can be accessible for everyone, it ensures that entire groups of people who are traditionally isolated from mainstream health care, including persons with disabilities, receive care and support on an equal basis with others. Inclusion also comes with socioeconomic advantages.[55] Mental health concerns everyone and when needed, services should be accessible and available to all at the primary and specialized care levels.

Essential psychosocial interventions

79. While psychotropic medications can be helpful, not everyone reacts well to them and in many cases they are not needed. Prescribing psychotropic medications, not because they are indicated and needed, but because effective psychosocial and public health interventions are not available, is incompatible with the right to health. For example, in most cases of mild and moderate depression "watchful waiting", psychosocial support and psychotherapy should be the frontline treatments.

80. Despite the right to health obligation to provide psychosocial interventions and support, they are sadly viewed as luxuries, rather than essential treatments, and therefore lack sustainable investment in health systems. That is despite evidence demonstrating that they are effective.[56] These are essential interventions, which produce positive health outcomes and safeguard individuals from potentially harmful, more invasive medicalization. Importantly, they can include simple, low-cost, short-term interventions delivered within regular community health-care settings. Nurses, general practitioners, midwives, social workers and community health workers must be equipped with psychosocial skills to ensure accessibility, integration and sustainability.[57] Psychosocial interventions, not medication, should be the first-line treatment options for the majority of people who experience mental health issues.

Mental distress and recovery

81. While the paradigm shift in mental health requires a move towards integrated and population-based services, mental distress will still occur and rights-based treatment responses are required. The interventions used to address serious cases are perhaps the biggest indictment of the biomedical tradition. Coercion, medicalization and exclusion, which are vestiges of traditional psychiatric care relationships, must be replaced with a modern understanding of recovery and evidence-based services that restore dignity and return rights holders to their families and communities. People can and do recover from even the most severe mental health conditions and go on to live full and rich lives.[58]

82. There is no single definition of recovery, often described as a personal journey towards regaining a meaningful life and becoming more resilient. The recovery approach, when implemented in conformity with human rights, has helped to break down power asymmetries, empowering individuals and making them agents of change rather than passive recipients of care. Tremendous strides have been made in this area, with evidence and recovery-based support and services in practice across the world today that restore people's hope (and trust) in services, as well as in themselves.

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[55] Lena Morgon Banks and Sarah Polack, "The economic costs of exclusion and gains of inclusion of people with disabilities. Evidence from low and middle income countries", London School of Hygiene and Tropical Medicine (2015), part B, sect. 3.

[56] See John Hunsley Katherine Elliott and Zoë Therrien, "The efficacy and effectiveness of psychological treatments for mood, anxiety and related disorders", *Canadian Psychology*, vol. 55, No. 3 (August 2014).

[57] See Clair Le Boutillier and others, "Staff understanding of recovery-orientated mental health practice: a systematic review and narrative synthesis", *Implementation Science*, vol. 10 (June 2015).

[58] See Richard Warner, "Does the scientific evidence support the recovery model?", *The Psychiatrist*, vol. 34, No. 1 (January 2010).

83. Peer support, when not compromised, is an integral part of recovery-based services.[59] It provides hope and empowers people to learn from each other, including through peer support networks, recovery colleges, club houses and peer-led crisis houses. Open Dialogue, a successful mental health system, has entirely replaced emergency, medicalized treatment in Lapland.[60] Other non-coercive models include mental health crisis units, respite houses, community development models for social inclusion, personal ombudsmen, empowerment psychiatry and family support conferencing. The Soteria House project is a long-standing recovery-based model, which has been recreated in many countries.[61] The increasing availability of alternatives and education and training on the use of non-consensual measures are critical indicators for measuring overall progress towards compliance with the right to health.

VII. Conclusions and recommendations

A. Conclusions

84. Mental health has often been neglected and when it does receive resources, it becomes dominated by ineffective and harmful models, attitudes and imbalances. That has led to the current situation of the grossly unmet need for rights-based mental health promotion and care. People of all ages, when they have mental health needs, too often suffer from either an absence of care and support or from services that are ineffective and harmful.

85. The failure of the status quo to address human rights violations in mental health-care systems is unacceptable. As mental health emerges as a policy priority, it is crucial now to assess the failure to chart a better way forward, reaching consensus on how to invest and how not to invest.

86. An assessment of the global burden of obstacles alarmingly suggests their burden may be heavier than any burden of "mental disorders". The crisis in mental health should be managed not as a crisis of individual conditions, but as a crisis of social obstacles which hinders individual rights. Mental health policies should address the "power imbalance" rather than "chemical imbalance".

87. The urgent need for a shift in approach should prioritize policy innovation at the population level, targeting social determinants and abandon the predominant medical model that seeks to cure individuals by targeting "disorders".

88. Today, there are unique opportunities for mental health. The international recognition of mental health as a global health imperative, including within the 2030 Sustainable Development Agenda, is welcome progress. The right to health framework offers guidance to States on how rights-based policies and investments must be directed to secure dignity and well-being for all. To reach parity between physical and mental health, mental health must be integrated in primary and general health care through the participation of all stakeholders in the development of public policies that address the underlying determinants. Effective psychosocial interventions in the community should be scaled up and the culture of coercion, isolation and excessive medicalization abandoned.

89. There are already promising initiatives in place throughout the world, including in low- and middle-income countries, which challenge the status quo. Creating the space, through strong political leadership and resources, to enable those

[59] See Sarah Carr, "Social care for marginalised communities: balancing self-organisation, micro-provision and mainstream support", University of Birmingham, policy paper No. 18 (February 2014).

[60] See Jaako Seikkula and others, "Five-year experience of first-episode nonaffective psychosis in open-dialogue approach: treatment principles, follow-up outcomes and two case studies", *Psychotherapy Research*, vol. 16, No. 2 (March 2006).

[61] See Tim Calton and others, "A systematic review of the Soteria paradigm for the treatment of people diagnosed with schizophrenia", *Schizophrenia Bulletin*, vol. 34, No. 1 (January 2008).

practices to take shape in communities is a powerful means to promote and advance the changes needed.

90. The Special Rapporteur seeks to develop, through an inclusive and participatory process and open dialogue, guidelines on human rights and mental health to support all stakeholders in the implementation of rights-based mental health policies in their respective areas of work. He welcomes contributions and suggestions in this respect.

B. Recommendations

91. The Special Rapporteur calls for leadership to confront the global burden of obstacles and embed rights-based mental health innovation in public policy. That includes State champions in international policy efforts, the leadership of professional psychiatry in assessing constructively its approach to the necessity for change, managers of mental health services leading change by example and municipal officials championing grassroots innovation. These champions must work in partnership with their constituents, including persons with intellectual, cognitive and psychosocial disabilities and with autism.

92. To address the imbalance of the biomedical approach in mental health services, the Special Rapporteur recommends that:

(a) States take immediate measures to establish inclusive and meaningful participatory frameworks in the design of and decision-making around public policy, to include, inter alia, psychologists, social workers, nurses, users of services, civil society and those living in poverty and in the most vulnerable situations;

(b) States and other relevant stakeholders, including academic institutions, recalibrate mental health research priorities to promote independent, qualitative and participatory social science research and research platforms, exploring alternative service models that are non-coercive;

(c) States partner with academic institutions to address the knowledge gap in rights-based and evidence-based mental health within medical education.

93. To ensure that social and underlying determinants for the promotion of mental health for all are addressed, the Special Rapporteur recommends that States:

(a) Prioritize mental health promotion and prevention in public policy, scaling investments across the relevant ministries;

(b) Take immediate action to develop public policies which, in alignment with the Sustainable Development Goals, address mental health and holistic development in early childhood and adolescence, prioritizing promotion and psychosocial interventions;

(c) Take policy and legislative measures on the prevention of violence in all environments where people live, study and work;

(d) Take immediate action to address harmful gender stereotypes, gender-based violence and access to sexual and reproductive health;

(e) Take immediate steps to eliminate the corporal punishment of children and their institutionalization, including children with disabilities.

94. To ensure that international cooperation secures the right to mental health and the 2030 Agenda, States and multilateral and international institutions should:

(a) End all financial support for segregated residential mental health institutions, large psychiatric hospitals and other segregated facilities and services;

(b) Mainstream the right to mental health into health, poverty-reduction and development strategies and interventions, and explicitly include it in general and priority health policies and plans;

(c) Advance global mental health in all monitoring activities of the Sustainable Development Goals, including high-level political forums.

95. **To ensure that health-care services guarantee the right to mental health for all, States should:**

(a) Ensure that users are involved in the design, implementation, delivery and evaluation of mental health services, systems and policies;

(b) Stop directing investment to institutional care and redirect it to community-based services;

(c) Invest in psychosocial services, that are integrated into primary care and community services to empower users and respect their autonomy;

(d) Scale up investment in alternative mental health services and support models;

(e) Develop a basic package of appropriate, acceptable (including culturally) and high-quality psychosocial interventions as a core component of universal health coverage;

(f) Take targeted, concrete measures to radically reduce medical coercion and facilitate the move towards an end to all forced psychiatric treatment and confinement;

(g) Seek technical assistance from the WHO QualityRights initiative to assess and improve the quality of mental health care.

United Nations A/HRC/35/21/Add.1

General Assembly

Distr.: General
20 April 2017

Original: English

Human Rights Council
Thirty-fifth session
6-23 June 2017
Agenda item 3
Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his visit to Algeria

Note by the Secretariat

The Secretariat has the honour to transmit to the Human Rights Council the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Pūras, on his visit to Algeria from 27 April to 10 May 2016. Algeria has made considerable progress with regard to the realization of the right to health, particularly improving basic health-related indicators and aligning most of the normative framework with its international human rights obligations. In the report, the Special Rapporteur encourages the Government to address a number of serious challenges that remain connected to the normative and policy framework and its implementation as well as to the prevalence of inequalities and discrimination against certain population groups, particularly women, adolescents and youth, people living with HIV/AIDS and drug users. The Special Rapporteur also addresses challenges affecting the national health system and the mental health framework and makes a number of recommendations.

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Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his visit to Algeria*

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* Circulated in the language of submission and French only.

I. Introduction

1. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Pūras, visited Algeria from 27 April to 10 May 2016 at the invitation of the Government. The purpose of the visit was to ascertain, in a spirit of dialogue and cooperation, how the country has endeavoured to implement the right to health.

2. During his visit, the Special Rapporteur met with high-ranking government officials from the Ministries of Employment and Social Security; Foreign Affairs; the Interior; Health, Population and Hospital Reform; National Education; National Solidarity, Family and Women; and Youth and Sports. He also met with members of the National Assembly Commission on Health, Labour and Social Welfare, the Health Commission of the Senate and the National Council, and held meetings with representatives of civil society, international organizations and United Nations funds and agencies.

3. The Special Rapporteur visited different health facilities, primary and secondary schools, drug dependency centres and one health-care facility for detainees, in different areas, including Algiers, Blida, Djelfa, Sétif and Oran.

4. The Special Rapporteur is grateful to the Government of Algeria for its invitation and full cooperation during his visit. He appreciates the significant support provided by the United Nations country team, including the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO).

II. Right to health framework

A. Background

5. Since Algeria gained independence in 1962, it has made considerable achievements in improving the health status of its population through sustained investment in public health. Revenues from hydrocarbon exports have enabled macroeconomic stability, economic growth and development over the past decades. This, together with an explicit commitment by the authorities, has paved the way for some achievements in the realization of the right to health.

6. The national health system was established on the predominance of the public sector and free access to preventive and curative services, so as to guarantee equity.[1] Health-related indicators have improved significantly since independence, including the life expectancy of most segments of the population, maternal and child mortality rates and successful vaccination campaigns. The country has also embarked on important social reforms, including universal free access to health care and education.

7. The health sector in Algeria has developed with a strong focus on primary care and universal free access for its population. Since independence, significant investments have been made to develop health infrastructure, make services available and accessible, and address the underlying determinants of health, including poverty, education, food and nutrition, and housing.

8. Although the effects of global financial crises have been felt since 2008, social expenditure focusing on disadvantaged groups represents about 12 per cent of the gross domestic product.[2] Despite the current financial crisis linked to the crash of international oil prices since mid-2014, the country has maintained its expenditure towards improving the health of its population. Concerted efforts are being made to address the challenges of the

[1] Algeria, *2ème Rapport National sur les Objectives du Millénaire pour le Development*, September 2010, p. 73.

[2] Ibid., p. 17.

ongoing demographic and epidemiological transitions in a country where almost 55 per cent of the population is below the age of 30 and non-communicable diseases have become a primary issue of concern.

9. Algeria still has high maternal and neonatal mortality and morbidity rates and significant disparities between urban and rural areas remain. The lack and insufficient quality of relevant health-related data and analytical studies are important deficiencies and challenges that seriously compromise public policy efforts in the health and health-related sectors.

10. The next two decades represent a critical juncture for the country to achieve two key and interrelated objectives: the Sustainable Development Goals by 2030 and the effective realization of the right to health of its population. Efforts made in these directions will be reinforced by the effective implementation of the WHO *Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)* and the technical guidance on the application of a human rights-based approach to reducing and eliminating preventable maternal and under-five mortality and morbidity (A/HRC/21/22 and A/HRC/27/31).

B. Normative and institutional framework

11. Algeria has ratified almost all of the international human rights treaties, except for the International Convention for the Protection of All Persons from Enforced Disappearance and some Optional Protocols — mainly those relating to individual complaints procedures.[3]

12. Algeria has introduced interpretative declarations and reservations with regard to provisions in the two International Covenants on Human Rights, the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women. This, together with the lack of ratification of the Optional Protocols on individual complaints procedures, undermines the nature and scope of its obligations under these treaties, including access to remedies and accountability with regard to the right to health.

13. Although the Government has accepted visits by a number of special procedure mandate holders of the Human Rights Council, it has yet to issue a standing invitation to all special procedure mandate holders. Algeria was evaluated under the universal periodic review in 2008 and 2012; its next review is scheduled for January 2017.

14. At the regional level, Algeria ratified the African Charter on Human and Peoples' Rights and has taken important health-related initiatives, in particular with regard to the eradication of malaria and the fight against HIV/AIDS.

15. The constitutional and normative framework recognizes the right to health and other related rights as well as the right to freedom from violence and discrimination. Pursuant to article 54 of the Constitution of 1989 (reinstated in 1996), "all citizens have the right to protection of their health" and the State "shall ensure the prevention and the fight against epidemics and endemic illnesses". Ordinance No. 73-65 of 28 December 1973 made the provision of both prevention and curative care free of charge. Health services are predominantly financed by the State, with limited but increasing private participation.[4]

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[3] Algeria has not yet acceded to the Optional Protocols to the following treaties: the International Covenant on Economic, Social and Cultural Rights; the Convention on the Rights of the Child, on a communications procedure; the Convention on the Elimination of All Forms of Discrimination against Women; the International Covenant on Civil and Political Rights, aiming at the abolition of the death penalty; and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

[4] African Commission on Human and Peoples' Rights, "Algeria: fifth and sixth periodic reports on the implementation of the African Charter on Human and Peoples' Rights" (December 2014), p. 44, and World Bank, "Algeria — Strengthening health system governance: Towards more effective regulatory environment for improved efficiency and quality of care", Concept note for technical assistance (December 2006), p. 3.

16. The most important law governing the right to health is the Health Protection and Promotion Act No. 85-05.[5] It sets out the basic principles and provisions regarding, inter alia, public health and epidemiology, mental health, the health workforce, and health financing. A new version of the Health Act is being developed in consultation with various stakeholders. The Special Rapporteur trusts that the new law will soon be adopted so as to guarantee equality, non-discrimination, effective participation and accountability in the enjoyment of the right to health.

17. The National Advisory Commission for the Promotion and Protection of Human Rights (*Commission nationale consultative de promotion et de protection des droits de l'homme*) was established in 2001. While it is in charge of monitoring, early warning and evaluating the realization of human rights, it is not authorized to receive complaints or conduct investigations.[6] In 2009, the Commission was accredited with "B" status for failure to implement the recommendations to bring it into conformity with the Principles relating to the status of national institutions for the promotion and protection of human rights (the Paris Principles), lack of a transparent and participatory appointment process and unsatisfactory interaction with the international human rights system.[7]

18. Several public policies, programmes and initiatives stem from this normative and institutional framework, including efforts to address the ongoing demographic and epidemiological transitions. The Special Rapporteur commends the efforts made to address inequities in accessing health in different parts of the country, such as twinning programmes (*jumelages*), the use of telemedicine and the establishment of mobile health units.

C. National health-care system

19. The Ministry of Health, Population and Hospital Reform manages the hospitals and the public health sector. There are five health regions across the country, with five regional health councils, five regional health observatories and 48 health and population directorates (one in each *wilaya*). The country is divided into 185 health districts.[8]

20. The health-care system has posted impressive results in making care available and accessible, with strengthened infrastructure, equipment and workforce. The population has financial coverage for most of the basic health services, which has contributed to a significant improvement in health indicators over the past decades.

21. Public investment in the national health system is among the highest in the region. In 2014, per capita health expenditure amounted to US$ 932; total health expenditure was 7.2 per cent of gross domestic product compared to 5.6 per cent in Egypt, 5.9 per cent in Morocco and 7.0 per cent in Tunisia. General public expenditure on health in 2014 was 9.9 per cent of total public expenditure. Out-of-pocket expenditure represented about 26.5 per cent of total expenditure on health in 2014.[9]

Priorities for strengthening the health-care system

22. Considerable challenges regarding equitable access to care, especially in the south, were identified in 2006, including allocative and technical inefficiencies under the hospital-centred delivery model, a poorly functioning primary-care network and dysfunctional hierarchy across health-care levels. The dissatisfaction of the population with the technical

[5] Algeria, Loi relative à la protection et à la promotion de la santé (Law on the protection and promotion of health). Available from www.mindbank.info/item/984.

[6] See Algeria, Presidential Decree No. 01-71 of 25 March 2001, and Ordinance No. 09-04 of 5 August 2009.

[7] See International Coordinating Committee of National Institutions for the Promotion and Protection of Human Rights, reports of the Subcommittee on Accreditation (April 2008 and March 2009).

[8] Algeria, National Advisory Commission for the Promotion and Protection of Human Rights, *Rapport annuel 2014*, p. 170.

[9] See WHO Global Health Observatory, Algeria. Available from http://apps.who.int/gho/data/node.main.75?lang=en.

quality of care provided in public facilities was also underlined, with those who can afford to pay out of pocket increasingly seeking care in the growing private sector.[9]

23. In 2007, Algeria launched the reform of its health system with the aim of improving the quality of services, ensuring efficiency of health-care establishments and the national health system in general, and minimizing disparities and inequalities among regions.

24. The health-care system was reorganized to bring health-care structures closer to the people: 195 public hospitals, 271 community health centres and 26 new mother-and-child hospitals were established. Specialized hospitals (*établissements hospitaliers spécialisés*) have independent status and funding and are dedicated to providing care to the target population.[10]

25. In an attempt to ensure equitable access to highly specialized health care, the 2014 Health Sector Development Framework envisaged the establishment of regional specialized centres and national referral centres to address the burden of morbidity linked to emerging pathologies, including cardiovascular diseases and different forms of cancer.

26. The Special Rapporteur visited various health-care structures in different parts of the country and found them to be in relatively good condition. However, he was made aware of deficiencies in infrastructure and equipment, and the lack of qualified health staff, especially in remote areas.[11]

27. The Committee on Economic, Social and Cultural Rights expressed concern about the availability of medicines, the insufficient quality of health care, in terms of standards of the upkeep of buildings, hygiene and reception of patients, as well as the poor conditions of work of health-care professionals in Algeria (see E/C.12/DZA/CO/4, para. 20).

Primary care as the path to universal coverage

28. There is a strong focus on primary (proximity) care and specialized services in Algeria, which is a good basis for reaching full coverage. However, significant challenges remain regarding equitable access to and the quality of services throughout the country and excessive emphasis on hospital care and specialized medicine.

29. The Special Rapporteur observed a disproportionate reliance on hospital care compared with attention paid to primary care, outpatient specialized care and health promotion and prevention. Between 2010 and 2015, the number of primary-care establishments remained the same (271 establishments), while the number of specialized centres increased from 64 to 75 and the number of medium-sized establishments also increased.[12]

30. Health-care systems function more effectively and rationally if general practitioners and their teams manage the majority of cases in primary-care structures. This allows resources to be accumulated for the expensive treatment of severe or complicated medical cases. In Algeria, there seems to be a lack of good governance and incentives to manage the different levels of health care in order to encourage the use of primary care.

31. The Government should invest in strengthening the role of general practitioners by building their capacities and competencies, as well as those of nurses, social workers and medical assistants, through continuous learning programmes. It should also consider establishing innovative incentives to consolidate the position of general practitioners as "gatekeepers" of the system, including with regard to children's health, mental health and the management of oncological and other non-communicable diseases.

[9] World Bank, "Algeria — Strengthening health system governance" (December 2006), p. 3.

[10] See Executive Decrees No. 07-140 of 19 May 2007 and No. 07-204 of 30 June 2007.

[11] Algeria, National Advisory Commission for the Promotion and Protection of Human Rights, *Rapport annuel 2014*, pp. 142-144 and 168-173; also *Rapport sur la visite des établissements hospitaliers (2008-2009)*, pp. 31-43.

[12] Figures provided by the Ministry of Health.

82. More efforts should be made to assess the performance of the national health-care system by establishing independent mechanisms and using indicators to measure the cost-effectiveness of investments in specialized health care, including the use of expensive diagnostic and therapeutic biomedical technologies.

83. Moreover, the Government should ensure that people in situations of poverty have the same access as others to specialized health-care centres, such as cancer treatment centres, and that they are not discriminated against when there are waiting lists.

84. The Special Rapporteur observed that, owing to the quality of care provided in the public sector and the dissatisfaction of service users, the private sector was growing fast and in an unregulated manner. This was leading to a dual system that offered better quality care for those who could afford to pay out of pocket or travel abroad to be treated, thereby increasing inequalities in access to health care.

Regional inequities in access to health care

85. Algeria has a population of over 39 million. Approximately 90 per cent of the population is concentrated on about 10 per cent of the territory in the north of the country, where most of the economic activity takes place.[14] One of the main challenges of the health-care system is linked to the significant regional disparities in socioeconomic indicators and infrastructure, in particular affecting those living in the southern and High Plateau regions.

86. Access to health care has improved over the past decades by the extension of health coverage in terms of infrastructure, staff and financing, and a deliberate policy by the Government. In 2008, geographic access to health facilities was measured at 98 per cent of the population.[15] However, concern was expressed about the difficulties faced by people living in rural areas in accessing health care, owing to an unequal geographic distribution of care facilities and medical practitioners (see E/C.12/DZA/CO/4, para. 20).

87. The Special Rapporteur visited the High Plateau region (Djelfa and Sétif) and noted some of the initiatives taken by the Government to address these inequities, in particular regarding access to specialized care. One such initiative is the twinning programme (*jumelage*) launched in 2014 and sanctioned by Executive Decree No. 16-197 of 4 July 2016.

88. The twinning programme is intended to encourage a partnership, whereby university hospitals in the north of the country would provide technical assistance and capacity-building to hospitals in the southern and High Plateau regions, which lack specialized personnel. In 2015, 207 missions, over 20,000 consultations and over 3,500 surgical interventions were carried out within this framework. A total of 53 public health centres, university hospitals and secondary-care centres have been included in the programme.[16]

89. The Special Rapporteur commends these efforts and encourages the Government to continue to improve access to health care and build the capacity of health structures in remote regions of the country. He reiterates the key role played by primary health structures and general practitioners and their teams.

Health workforce, transparency, accountability and participation

90. The health sector in Algeria is the second largest public service employer with 18 per cent of all female public officials. Training for the basic medical degree, doctor of medicine (MD) lasts six or seven years. The licence to practise medicine is granted by the Ministry of Health. There are South-South cooperation programmes aimed at reinforcing capacities in the health sector, including in specialized fields such as ophthalmology.

[14] Algeria, National Advisory Commission for the Promotion and Protection of Human Rights, *Rapport annuel 2014*, pp. 130-133.

[15] World Bank, "Algeria: Strengthening health system governance" (December 2006), p. 4.

[16] Data provided by the Ministry of Health.

41. Health-care workers in the public sector are generally underpaid, which places the workforce in a precarious situation that is often aggravated by the prevalence of temporary contracts without maternity or sick leave entitlements (see E/C.12/DZA/CO/4, para. 10). As such, many health-care workers opt to leave the country.

42. In order to prevent the brain drain, investing in human resources is crucial, including decent salaries for health-care workers and improved working conditions, as well as strengthening the independence and building the capacities of health professionals. They should enjoy ownership of their professional activities and have self-regulation capacity with regard to setting professional standards relating to clinical and ethical issues.

43. While the country is taking important steps to strengthen data collection and statistical systems to meet international standards, there is a need to improve the availability of high-quality data to better inform public policies and action. Effective health information systems, civil registration systems and disaggregated data should be in place for adequate situation analysis, identification of gaps and proper monitoring, review and oversight of performance. More efforts are needed to ensure proper accountability in the health-care sector, including through nationally led evaluations and the establishment of independent monitoring mechanisms of health policies and programmes.

44. Algeria should reinforce investment to enhance transparency and the meaningful participation of all stakeholders, including users and providers of health services, independent civil society and local authorities. Consultations organized in June 2014 in the context of the revision of the Health Act were a positive sign in this direction.

III. Right to health of key populations and groups

45. Significant inequalities persist in the enjoyment of the right to health, expressed in the form of barriers hindering access to and affecting the quality of essential services, in particular in rural and remote areas of the country. This disproportionally affects groups in situations of poverty and those living in the south and High Plateau regions.

46. In addition, certain population groups face discrimination and specific challenges in realizing their right to health, including women, adolescents and youth, persons with disabilities, drug users and people living with HIV/AIDS. The Special Rapporteur also looked at the mental health framework in the country.

A. Women

47. Women have enjoyed an overall improvement in health indicators since independence, including increased life expectancy, decreased maternal mortality rates and the fight against infectious and, more recently, non-communicable diseases. The Special Rapporteur commends the Government for the efforts made over the past few years to address the prevention and treatment of cancer, including breast and cervical cancers.

48. While women have access to the education system at all levels, are represented at various levels of national and local government and form a large part of the health-care workforce, including as medical professionals, the ongoing demographic transition has implied a significant decrease in fertility rates.

49. In addition, serious challenges remain when it comes to the full realization of women's right to health, including barriers to the enjoyment of sexual and reproductive health rights and the effective implementation of a normative framework on violence against women.

50. The health-care sector is one of the best placed public sectors to ensure that women are adequately supported, protected and empowered through equitable access to quality services and evidence-based information. However, women's full realization of the right to health requires more than service provision. Attention should be paid to the underlying social determinants such as violence, poverty and discrimination, which are often

reinforced by patriarchal gender norms and stereotypes as well as restrictive interpretations of cultural and religious norms and practices.

Maternal and child mortality and morbidity

51. Algeria ranks below the global average on maternal mortality and morbidity, but slightly above the regional average for the Middle East and North Africa.[17] Despite notable progress made over the past decades in reducing the maternal and neonatal mortality ratio, from 230 maternal deaths per 100,000 live births in 1989 to 63.6 in 2014, the country fell short of meeting the Millennium Development Goal 5 target on reducing maternal mortality, which was 57 per 100,000 live births (see DP/FPA/CPD/DZA/6, para. 6).

52. In 2012, the Committee on the Rights of the Child expressed concern about the high levels of maternal, neonatal and under-five mortality rates (see CRC/C/DZA/CO/3-4, para. 57). The health of mothers and young children has become a national priority in health care and social services in Algeria.

53. The legislative basis for the maternal and child mortality and morbidity policy is the Health Act, which addresses family planning with the aim of promoting a harmonious family balance and preserving the lives and health of mothers and young children. In addition, chapter V (arts. 67-75) of the Health Act sets out measures for the protection of mothers and young children. The National Perinatal Care Programme 2006-2009 was launched in 2005 and aimed at a 30-per cent reduction in perinatal mortality and a 50-per cent reduction in maternal mortality.[18]

54. The majority of maternal deaths are preventable and there is a higher rate of such deaths in remote rural regions. The situation underscores persistent inequalities in access to health care, as well as in the enjoyment of the underlying and social determinants of women's health, with some regions being noticeably worse off than others. Rural regions and the south are most affected by poverty and social exclusion and rank higher in relation to the absence of monitoring during pregnancy and unaccompanied births.[19]

55. Over the past decade, the monitoring of mothers-to-be and specialized support and care have improved, with the proportion of births attended by skilled personnel increasing from 76 per cent in 1990 to 96.6 per cent in 2013. This is crucial for reducing perinatal, neonatal and maternal deaths. Furthermore, over the past decade, antenatal care coverage has increased significantly.

56. The under-five mortality rate (deaths per 1,000 live births) was reduced by 45.5 per cent from 46.8 in 1990 to 25.6 in 2015. Similarly, the infant mortality rate was reduced by 44.8 per cent from 39.7 in 1990 to 21.9 in 2015. The neonatal mortality rate (deaths per 100,000 live births) was estimated to be 15.5 in 2015. While child mortality rates have reduced significantly, Algeria did not meet the Millennium Development Goal target to reduce child mortality by two thirds in 2015, mainly owing to the prevalence of high neonatal mortality rates.

57. The main causes of death in children under 5 years of age include premature birth (20 per cent); congenital anomalies (18 per cent); birth asphyxia (13 per cent); and acute respiratory infections (13 per cent). Nonetheless, the proportion of infants (under 1 year of age) immunized against measles increased from 83 per cent in 1990 to 95 per cent in 2015 and the prevalence of underweight children under 5 years of age was reduced from 9.2 per cent in 1992 to 3 per cent in 2012/2013.[20]

58. The National Plan for the Reduction of Maternal Mortality (2014) of the Ministry of Health, in partnership with UNICEF, addressed maternal mortality and inequities through five strategic interventions: improving governance; reaching every woman to reduce

[17] See World Bank, MDG Progress Status, Algeria. Available from http://data.worldbank.org/mdgs/compare-trends-and-targets-of-each-mdg-indicator.

[18] Also Executive Decree No. 05-435 (2005).

[19] UNICEF Annual Report 2014: Algeria, p. 18.

[20] See WHO Global Health Observatory. Available from https://apps.who.int/gho/data/node.home.

inequalities; strengthening family planning; raising the quality of prenatal and postnatal care; and promoting women's and caregivers' participation. The plan also envisaged the launch of a maternal death audit system and a reference guide on obstetric care standards.[21]

59. The Special Rapporteur acknowledges the achievements made in reducing maternal and child mortality rates, as well as the important work currently being carried out by the Government, with the support of United Nations agencies, to reduce maternal and neonatal mortality. He commends the reinforcement and expansion of the hospital and care network to offer maternal and neonatal care services throughout the country. Emergency obstetric care is a core obligation and a crucial maternal health intervention. In this sense, the maternal death audit system established in 2014 and the reference guide on obstetric care standards developed in 2016 are key tools for operationalizing obligations and commitments, and should be effectively implemented.

60. However, commitments at the highest level of government need to be accompanied by comprehensive measures to ensure substantive equality for women throughout the country. This implies simultaneous attention to short-term life-saving interventions and long-term socioeconomic and political transformations to address broader patterns of discrimination and violence against women and children which affect maternal, neonatal and under-five mortality and morbidity (see A/HRC/21/22, para. 65).

61. Addressing the underlying and social determinants of maternal and neonatal mortality and morbidity is essential. Poverty, low education levels, insufficient access to health services, gender discrimination and lack of empowerment are barriers hindering women from making the best informed choices about their sexual and reproductive health and the health of their children, which results in poorer health outcomes and higher risks (A/HRC/27/31, para. 74).

62. Sexual and reproductive health rights are an integral part of the right to health.[22] The sexual and reproductive health services most needed by women, in particular young women, include access to safe, reliable and good quality contraception, comprehensive maternal health services, safe abortion and treatment for complications from unsafe abortion, and prevention and treatment of sexually transmitted infections and HIV/AIDS (see E/CN.9/2014/4, paras. 68-77).

63. Therapeutic interruption of pregnancies is allowed in Algeria, with a few exceptions. The Penal Code of 8 June 1966 prohibits abortion unless it is performed as an indispensable measure to save the life of the mother (arts. 304-313) and, under the Health Act, abortions may be performed as an essential measure to save the woman's life if in danger or to preserve her mental equilibrium if it is seriously threatened (art. 72).

64. However, interruption of pregnancy in cases of rape and incest is not allowed under the current legal framework. A woman inducing or agreeing to the inducement of her own abortion is subject to imprisonment for a period of 6 to 24 months and a fine. The person who performs the abortion is subject to imprisonment of one to five years and a fine. If that person is a medical practitioner, he or she may also be suspended from practising his or her profession.[23]

65. The criminalization of abortion forces many women to seek unsafe clandestine abortions, which are extremely dangerous for their health and lives. It also exposes women to additional dangers, violence and stigma which are additional barriers to the full enjoyment of their right to health. The Government should review the normative framework with a view to decriminalizing abortion and guaranteeing access to services for the therapeutic interruption of pregnancy, at the least when the pregnancy is the result of rape or incest, in cases of grave and severe fetal impairment and when the life and health of the

[21] UNICEF Annual Report 2014: Algeria, p. 19.

[22] See Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016) on the right to sexual and reproductive health, para. 1.

[23] See Algeria, Penal Code, arts. 304-309.

woman is in danger. The necessary information and training should be provided to the relevant health professionals.[24]

Violence against women and girls

66. The prevalence of violence against women, including domestic violence, poses serious human rights concerns and is a serious public health issue that should be addressed without delay. In 2006, a national survey on violence against women revealed that 9.4 per cent of Algerian women between the ages of 19 and 64 years had encountered physical violence often or daily within the family and that 31.4 per cent had been regularly subjected to threats of physical or psychological violence. The survey also found that marital rape and other forms of sexual abuse existed, with 10.9 per cent of women admitting that they had been subjected to forced sexual relations on more than one occasion by their intimate partners.[25]

67. Following her visit to the country in 2010, the Special Rapporteur on violence against women, its causes and consequences acknowledged notable progress made at the legislative and institutional levels, but highlighted several issues which remained of particular concern, including violence against women in the family, sexual harassment at work and in educational and training institutions and stigmatization of and hostility towards unmarried single women and women living on their own. She stated that women's vulnerability to violence was heightened by patriarchal mentalities, challenges in the interpretation and implementation of the law and the absence of verifiable statistics on the prevalence of violence (see A/HRC/17/26/Add.3, paras. 12-23).

68. Violence against women is a severely underreported phenomenon worldwide because the women affected fear that disclosure will lead to stigmatization, and both victims and witnesses fear that they would not receive adequate protection, particularly in criminal cases. It is estimated that the figures reported represent only the tip of the iceberg.

69. The National Strategy for Combating Violence against Women provides for women victims to have access to medical and psychological care, legal support and professional training, with a view to their social and economic reintegration. In addition, the National Security Directorate has implemented several preventive security measures aimed at combating violence against women, such as the establishment of counselling services at city police stations. However, concern was expressed about the lack of a policy for medical personnel to monitor and report cases of domestic violence against women (see CEDAW/C/DZA/CO/3-4, para. 40).

70. To break the vicious cycle of violence, there must be a clear and strong political will to ensure that the normative and policy framework protects and empowers women and to address gender-based stereotypes, assumptions and expectations that place women in a subordinate role in society. In this connection, the Special Rapporteur points to gaps in the normative framework that should be addressed.

71. Certain provisions of the Penal Code remain problematic with regard to different forms of gender-based violence. Article 336 criminalizes rape, but does not provide a definition of the offence as a violation of an individual's physical and mental integrity, and marital rape is not recognized as a criminal offence. Article 326 makes abduction or corruption of or the attempt to abduct or corrupt a minor under 18 years, without violence, threats or deception an offence punishable by imprisonment of one to five years. However, if the perpetrator marries the minor, he is not liable to prosecution or conviction until the marriage is annulled.

72. The Penal Code does not define other forms of sexual violence, such as sexual assault, but such acts may be prosecuted under articles 334 and 335 covering indecent assaults (*attentat à la pudeur*). However, these provisions have limited scope as they do not

[24] See WHO, *Safe abortion: technical and policy guidance for health systems*, 2nd ed. (2012).

[25] See Algeria, Ministry responsible for the Family and the Status of Women, *Violence à l'égard des femmes en Algérie : enquête nationale de prévalence* (2006).

cover non-violent acts against adults or minors who, owing to early marriage, are treated as adults.

73. The Penal Code criminalizes adultery (art. 339) and homosexuality (art. 338). However, it has been reported that victims of sexual violence are deterred from filing a complaint for fear of finding themselves prosecuted under these provisions. The introduction in 2004 of sexual harassment as a criminal offence was limited to instances of sexual harassment by a person abusing his position of authority in the workplace (art. 341 bis).

74. The Special Rapporteur welcomes the draft law on comprehensive protection for women against all forms of violence, which was passed at first reading in Parliament in December 2015. He trusts that it will be adopted and implemented without delay.

75. In February 2016, amendments to the Penal Code introducing penalties for domestic violence and violence against women, including sexual harassment, were passed. These amendments had been blocked by the Senate for eight months amid resistance from conservative groups that viewed them as interference in family affairs. The Special Rapporteur commends these amendments and urges the authorities to address without delay the remaining gaps in legislation and in practice regarding gender-based violence so as to uphold women's right to health and related rights.

B. Adolescents and youth

76. In 2012, about 16.6 per cent of the population of Algeria was aged 10 to 19 years.[26] In 2016, adolescents and youth aged 10 to 24 years represented about one quarter of the population. Given the ongoing demographic transition over the past decades, with lower fertility rates (about 3 children per woman in 2014) and increased life expectancy, adolescents and youth comprise a very important segment of the population and offer a unique opportunity for the country to reap the demographic dividend. This group can play a decisive role in effectively achieving the health-related Sustainable Development Goals.

77. Algeria acceded to the Convention on the Rights of the Child in 1990 but has made interpretative declarations to certain provisions (arts. 14 (1) and (2), 13, 16 and 17), which place national legislation before international law and amount to reservations. To date, Algeria has not ratified the Optional Protocol to the Convention on a communications procedure, which would allow individuals effective access to justice and redress for violations of their rights.

78. A national strategy for combating violence against children was launched in 2005, jointly with UNICEF. The strategy emphasizes the prevention of violence, intervention by relevant agents, child protection and the social reintegration of victims. According to the strategy, key public officials, including teachers, social workers and educational social workers, have a duty to report allegations of violence at school or within the family (see CRC/C/DZA/3-4, para. 101 (c)).

79. In 2008, the Government adopted the National Plan of Action for the Protection and Welfare of Children, entitled "An Algeria fit for children", for the period 2008 to 2015. The Plan covered four main areas: rights of the child, promoting a healthy and better life; quality of education; and child protection (see CRC/C/DZA/3-4, para. 46). The Special Rapporteur was not able to ascertain whether the plan had been reviewed in 2010, as was foreseen, and whether its impact had been assessed after 2015. On 15 July 2015, Algeria adopted Law No. 15-12 on the protection of children.

80. The Committee on the Rights of the Child raised some important issues relating to the right to health of children and adolescents but many of them do not seem to have been adequately addressed as yet. For example, sexual and reproductive health services for

[26] See UNICEF, statistics on Algeria. Available from www.unicef.org/infobycountry/algeria_statistics.html#123.

adolescents remain inadequate and comprehensive age-sensitive sexual education and information is generally unavailable.

81. The Special Rapporteur observed a lack of effective implementation and impact assessment of policy measures addressing children, owing to limited political will and insufficient financial and technical resources, including reliable disaggregated data and indicators. To date, an independent national institution for the promotion and protection of children's rights has not been established.

82. An intersectoral public policy on sexual and reproductive health rights aimed at adolescents within and outside the educational system should be designed and implemented. This policy should take into account sexual and reproductive health rights, healthy sexuality, prevention of unplanned pregnancies and sexually transmitted diseases, including HIV/AIDS, and use of all types of contraceptives.

83. Adolescents and youth should be seen as rights holders and should be meaningfully involved in all matters and decisions affecting them. Services need to be adolescent- and youth-friendly, so that they are trusted and not avoided. This is especially important with regard to their mental health and emotional well-being, in particular to prevent suicide and ensure early identification of mental health conditions, and crucial when it comes to drug use. Adolescents and youth should be empowered to exercise their right to health according to their evolving capacities so that they are responsible and fully able to control their health and lives when they reach adulthood.

Right to health in schools

84. The Special Rapporteur visited several primary and secondary schools in different areas and commends the efforts aimed at ensuring access to basic health services in primary and secondary schools. Health in schools is considered a key pillar of the public health system and a range of preventive, curative and educational services are provided to children and adolescents.

85. Since 2005, the Programme for the Promotion and Protection of Health in the School Environment has been implemented by the Ministries of Health and National Education. It has a multidisciplinary and multisectoral approach with the participation of students and parent associations. Its main objectives are to guarantee optimal coverage through vaccinations, health screenings and educational campaigns and to ensure adequate conditions regarding hygiene, food and infrastructure in schools.

86. Under the programme, screening and follow-up units (*unités de dépistage et de suivi*) composed of multidisciplinary teams of doctors, dentists, psychologists and paramedical personnel have been established in schools. The teams are part of the daily life in schools and integrate their health-related programmes in coordination with the educational teams.

87. In 2016, there were a total of 1,831 such units, of which 1,343 (1,159 full-time; 184 part-time) were located in schools throughout the country and employed over 2,000 doctors, dentists and paramedical personnel and over 1,500 psychologists.

88. The Special Rapporteur visited several of these units and commends the efforts. Schools offer excellent opportunities to promote the health and well-being of children, including through the implementation of comprehensive programmes and the provision of health-related education and evidence-based information to address patterns of discrimination and other barriers to the enjoyment of the right to health of the children, adolescents and youth.

89. Algeria has established a good model to prevent discrimination and exclusion of children in relation to accessing basic health services linked to the enjoyment of the highest attainable standard of physical health. However, inadequate screening for emotional and behavioural health conditions and identification of developmental disabilities or emotional difficulties in children have led to children being excluded from mainstream schools. The Special Rapporteur recommends that a better balance be struck to address both physical health and mental health in the school setting.

90. There are unique health challenges facing adolescents and youth (see A/HRC/32/32), but investing in the health and health rights of adolescents and youth, including their education and participation, can galvanize a vast human potential in the context of the 2030 Agenda for Sustainable Development, in particular in countries like Algeria, where a demographic transition is taking place.[27]

C. People living with HIV/AIDS

91. Algeria has a low prevalence rate of HIV/AIDS, estimated at below 0.1 per cent of the population. The rate is considerably higher for men who have sex with men (3.7 per cent) and sex workers (4.7 per cent). Prevalence in people who inject drugs is approximately 2.9 per cent.[28]

92. In 2015, it was estimated that 8,800 people of all ages were living with AIDS in Algeria. Reportedly, about 90 per cent of persons living with HIV (7,915) received antiretroviral therapy; around 500 women living with HIV were in need of antiretrovirals to prevent mother-to-child transmission; and about 112 pregnant women (about 25 per cent) actually received antiretrovirals in 2015.[29]

93. Available data indicate that fewer than 17 per cent of women in Algeria know where to go to be tested for HIV; only 2 per cent benefit from HIV counselling and testing when receiving maternal care; and only 1 per cent of pregnant women has been tested for HIV/AIDS.[30] Regarding comprehensive knowledge of HIV among young girls and women (ages 15-24), data show low levels of awareness and stark differences between those in urban and rural areas.[31]

94. The institutional framework for HIV care was significantly strengthened during the 1990s with the establishment of the National Blood Agency in charge of blood transfusion safety; compulsory screening for blood donations and other blood-related activities throughout the national territory; the establishment of 15 referral centres for HIV/AIDS; and the supply of free antiretroviral drugs in those centres.[32] The National Committee for Combating and Preventing HIV/AIDS and Sexually Transmitted Diseases acts as the national coordinating body.[33]

95. The Government has put in place policies and programmes to fight the spread of and ensure access to treatment for those living with HIV/AIDS, including through testing centres and the National Strategy on the Elimination of Mother-to-Child Transmission of HIV/AIDS 2013-2015.

96. In 2011, there were 59 testing and counselling facilities in Algeria,[34] and 61 screening centres have been opened in *wilayas* across the country providing confidential and free services. In 2012, UNAIDS and the Ministry of Health announced the establishment of a dedicated HIV/AIDS research centre in Tamanrasset in southern Algeria, which has yet to materialize. Prevention activities target youth in particular and are conducted through school and university health programmes and multisectoral mechanisms,

[27] WHO, *Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)*, p. 11.

[28] See http://aidsinfo.unaids.org/.

[29] See http://aidsinfo.unaids.org/.

[30] UNICEF Annual Report 2014: Algeria, pp. 18-19.

[31] See UNICEF statistics on Algeria. Available from www.unicef.org/infobycountry/algeria_statistics.html.

[32] See African Commission on Human and Peoples' Rights, "Algeria: fifth and sixth periodic reports" (December 2014), para. 65.

[33] See UNAIDS Country Progress Report 2014. Available from www.unaids.org/sites/default/files/country/documents/DZA_narrative_report_2015.pdf.

[34] See WHO Global Health Observatory. Available from http://apps.who.int/gho/data/node.main.625TC?lang=en.

in particular the partnership between UNAIDS and the National Office for the Fight against Drug Use and Drug Addiction.[35]

97. The National Strategic Plan 2016-2020 aims to achieve the UNAIDS 90-90-90 goal: by 2020, 90 per cent of all people living with HIV will know their HIV status; 90 per cent of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; and 90 per cent of all people receiving antiretroviral therapy will have viral suppression.

98. However, during his visit, the Special Rapporteur noted that the key populations faced serious barriers, in law and in practice, to the enjoyment of the right to health. HIV/AIDS remains a taboo in Algerian society. People living with HIV/AIDS face different forms of discrimination and stigma in accessing health care and treatment, and tend to avoid using health services.

99. Algeria does not have legislation specifically prohibiting non-discrimination of persons living with HIV/AIDS. General provisions on the prohibition of discrimination are contained in, inter alia, the Constitution (art. 29) and the Code of Medical Ethics (art. 7). In 2005, the Family Code was amended (by Ordinance No. 05-02 of 27 February 2005) to introduce an obligatory prenuptial medical examination as part of the marriage procedure, which may include HIV testing. Although the test results do not prevent couples from getting married, this requirement is incompatible with obligations under the right to health as it infringes upon the rights to privacy, autonomy and refusal of non-consensual treatment.

100. The Penal Code criminalizes homosexuality and sex work (arts. 338, 343 and 347), which is not only discriminatory, but can have dramatic public health effects. While the adoption of health-related policies and programmes targeting key affected populations is commendable, it does not offset the impact of criminalization, which is a serious barrier to the enjoyment of the right to health of those at risk, driving them away from the services they need and increasing health-related risks for them and society as a whole.

101. Algeria is a major transit hub for irregular mixed population movements. Over the past few years, the number of migrants in the country has increased, including migrant workers and undocumented migrants. Overall, migrants, including those in irregular situations, have access to health-care services free of charge. However, there is a lack of reliable disaggregated data to assess and monitor their situation from a right-to-health perspective. This is of concern since mobility is a determining factor for the HIV/AIDS epidemic and other communicable diseases.

102. More efforts are needed to actively reach out to those populations both as a preventive measure but also to ensure effective access to health services. The Special Rapporteur strongly recommends that the Government decriminalize homosexuality and sex work and implement awareness-raising campaigns to combat discrimination against persons living with HVI/AIDS, in particular in health-care services. In addition, age-appropriate evidence-based educational modules on HIV/AIDS transmission and prevention should be included in the school curriculum.

103. The Sustainable Development Goals aim to eliminate HIV/AIDS by 2030. Algeria has made considerable progress in this direction and could achieve this goal and lead efforts in the region. However, this cannot be accomplished without the normative and societal changes necessary to achieve zero discrimination, in particular in health-care services.

D. People who use drugs

104. Owing to its geographical location between two sensitive cannabis production and consumption areas, Algeria continues to be classified as a transit country for drug trafficking.[36] While drug addiction has been a public health issue for decades in many

[35] See African Commission on Human and Peoples' Rights, "Algeria: fifth and sixth periodic reports" (December 2014), para. 63.

[36] Pompidou Group of the Council of Europe, "Drug situation and policy in Algeria" (2014), p. 9.

countries, according to official sources, the phenomenon of drug use and addiction is relatively recent in Algeria.[37] Nowadays, both domestic production and consumption are on the rise and drugs are more easily accessible in all sectors of society.

105. Drug use was, until recently, taboo in Algerian society and considerable progress has been made in addressing the issue over the past decades. A national epidemiological survey carried out in 2010 showed that the most frequently consumed drugs in Algeria were cannabis and psychotropic substances. The number of consumers of psychoactive substances is estimated to be around 300,000, aged 12 and above, that is, 1.15 per cent of the population, with a clear predominance among persons between 20 and 39 years of age.[38] The situation of people who inject drugs in Algeria is undocumented and harm-reduction services are generally unavailable.

106. Shortly after independence, Algeria acceded to and ratified the 1961 Single Convention on Narcotic Drugs (by Decree No. 63-343 of 11 September 1963) and subsequently ratified the 1971 Convention on Psychotropic Substances (by Decree No. 77-177 of 7 December 1977) and the 1988 Convention against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances (by Decree No. 95-41 of 28 February 1995). However, some years elapsed before legislation on drug use was adopted. Order No. 75-9 of 17 February 1975 on penalties for trafficking in and the illicit use of poisonous substances and narcotics merely laid down penalties for drug-related offences.

107. The Health Act provides that, in the future, the production, transport, import, export, possession, supply, transfer, acquisition or use of narcotic or non-narcotic poisonous substances or plants, and the cultivation of such plants, will be governed by a regulation (sect. 190); and contains criminal-law provisions concerning drug-related offences (sects. 242-259).

108. Law No. 04-18 of 25 December 2004 on the Prevention and Repression of Illicit Use and Trafficking of Narcotics and Psychotropic Substances is regarded as the most important piece of drug legislation in Algeria. The law makes a distinction between victims and criminals and provides for the possible waiving of court proceedings against those who agree to undergo medical treatment or rehabilitation (arts. 6-12). Under these provisions, drug users may avoid criminal prosecution if, as per a court order, they agree to undergo curative and detoxification treatment at specialized establishments under the supervision of health personnel.

109. The Special Rapporteur acknowledges the efforts made to address drug use through non-custodial measures. However, he considers that granting the criminal courts jurisdiction over a public health issue by issuing drug "treatment and testing orders" as an alternative to imprisonment could be considered as a form of coerced treatment, which does not necessarily ensure the protection of drug users' rights and is not an effective public health measure.

110. Drug use does not always equate to drug addiction and certain users do not require rehabilitation or medical treatment. Adequate safeguards should be in place to guarantee the promotion and protection of the rights of drug users to access evidence-based information about substance use and addiction. Adequate health services should be put in place based on informed consent and the right to refuse treatment, a key element of the dignity and autonomy of those individuals affected. Drug use should not be a criminal offence and restorative measures should be put in place to address such behaviours outside the criminal justice system, particularly with regard to adolescents and youth.

Available from www.coe.int/T/DG3/Pompidou/Source/Images/country%20profiles%20flags/profiles/CP%20Algeria%20English%2044s-X3.pdf.

[37] See, for example, Algeria, Ministry of Health, Population and Hospital Reform, "Programme de lutte contre la toxicomanie", p. 1. Available from www.mindbank.info/item/5323.

[38] Algeria, Ministry of Justice, "Enquête épidémiologique nationale et globale sur la prévalence de la drogue en Algérie" (September 2010), p. 13. Available from www.plateforme-elsa.org/files/Enquete_Nationale_Algerie_UD_2010.pdf.

111. Over the years, a number of institutions have been established to address drug use and addiction in Algeria. Since 2002, the National Office for the Fight against Drug Use and Drug Addiction has been the main body dealing with such issues.

112. Currently, there are two centres for the prevention and treatment of drug addiction, in Blida (since 1996) and in Sidi Chami, Oran (since 1997). There are three intermediary centres for treating drug addiction in Annaba, Sétif and Bab El Oued (Algiers). The 2007-2009 National Action Plan on Drug Use and Drug Addiction created 15 drug treatment centres and 53 intermediary centres throughout the country. Each *wilaya* is supposed to have at least one intermediary centre (see CRC/C/DZA/3-4, paras. 179-180). In 2013, it was reported that 25 intermediary centres had been established and were operational. In the same year, existing treatment centres and intermediary centres reported 14,936 consultations and 1,477 hospitalizations, including 96 for court-ordered treatment.[39]

113. The Special Rapporteur visited the treatment centres in Oran and Blida, which have specific programmes and services for drug users, and had the opportunity to speak to health providers and service users. Although the structures and programmes seem to have a good approach, they should be accompanied by appropriate harm-reduction services at the community level and by education and information campaigns and programmes, particularly for reaching out to adolescents and youth.

114. The health and related sectors and authorities, including the ministries responsible for education and youth, should be more active in promoting participatory and evidence-based prevention services and treatment for people who use drugs. The Government of Algeria should make sure that its normative framework does not criminalize drug use and minor drug-related offences, and should continue to promote non-punitive and non-custodial public health measures that ensure respect for the dignity and autonomy of those concerned.

IV. Mental health framework

115. Mental health conditions account for 6 per cent of the causes of disabilities in Algeria. For the population as a whole, the incidence of mental health conditions has been estimated at 0.5 per cent for both sexes (see E/C.12/DZA/4, para. 296).[40] An epidemiological study carried out by the Ministry of Health in 2004 showed that chronic mental disorders were diagnosed in 0.7 per cent to 1.9 per cent of subjects in different age groups. Those below 40 years of age and women were particularly affected.[41]

116. In 2011, public expenditure on mental health accounted for 7.3 per cent of the total health budget, of which expenditure on inpatient hospitalization represented 81.44 per cent of the total mental health budget. Algeria has an urgent need for qualified human resources in the mental health sector. For a number of years now, different programmes have been set up to strengthen the training of mental health professionals (psychiatrists, nurses, psychologists) and increase the number of mental-health positions.[42]

117. Violence in the country during the 1990s, known as the "Black Decade", including sexual violence, has had a detrimental impact on the enjoyment of the right to physical and mental health of the population. It is estimated that up to 92 per cent of the Algerian population witnessed acts of violence during this time, with the consequent negative impact on their mental health. Several treaty bodies have expressed concern about the failure of the Government to provide adequate psychological support to victims of violence, including

[39] Pompidou Group of the Council of Europe, "Drug situation and policy in Algeria" (2014), p. 28.

[40] Also Pan Arab Project on Family Health, *Enquête Algérienne sur la santé de la famille* (2002), p. 39. Available from www.sante.gov.dz/images/population/RAPPORT%20FINAL%20PAPFAM.pdf.

[41] WHO Mental Health Atlas 2005, p. 54. Available from www.who.int/mental_health/evidence/atlas/profiles_countries_a_b.pdf?ua=1.

[42] See WHO Mental Health Atlas 2011, Algeria. Available from www.who.int/mental_health/evidence/atlas/profiles/dza_mh_profile.pdf.

those who experienced sexual violence during the 1990s (see CAT/C/DZA/CO/3 and E/C.12/DZA/CO/4).

118. Law No. 98-09 of 1998 is the most recent legislation relating to mental health. Mental health provisions are also included in the Health Act (arts. 103-149). In the context of the review of this law, the section on mental health will be substantially enhanced to reinforce the prevention of mental health conditions and guarantee patients' rights.[43] The Government ratified the Convention on the Rights of Persons with Disabilities in 2009 and submitted its initial report to the Committee in 2015.

119. The updated Mental Health Policy 2016-2020 covers prevention, treatment and rehabilitation with an intersectoral and a life course approach, in line with WHO *Mental Health Action Plan (2013-2020)*.[44] Previous mental health policies reportedly faced challenges in their implementation.[45]

120. The National Programme on Mental Health (2010-2013) considered the provision of mental health care with a focus on decentralized primary health care, a community-based approach and the greater availability of medications; the update of mental health legislation; the development of programmes to prevent mental conditions; psychological and social rehabilitation programmes for victims of violence; and information campaigns to educate professionals and the general public as well as communities and families (see E/C.12/DZA/4, para. 297). Objectives included the strengthening of curative and preventive care through the inclusion of the private sector (160 private psychiatric practices) and the promotion of partnerships and cooperation with other sectors concerned (see CEDAW/C/DZA/3-4, pp. 88-89).

121. The Algerian authorities have underlined their commitment to maintaining public spending on mental health to ensure access to free services without discrimination. The first steps to develop general mental health services for children and adults should be commended; however, such initiatives still remain pilot projects and need to be further developed and replicated. It is a good sign that psychologists are working in the health and education sectors and that psychiatrists are working in proximity health centres. But this is not enough for modern human rights-based mental health policies and services to be in place.

122. The mental health sector in Algeria is excessively reliant on psychiatric hospitals and inpatient care. Instead of building new psychiatric hospitals, each general hospital should have an inpatient psychiatric unit to make mental health care more accessible to all and avoid stigmatization. Although the availability of mental health services in primary-care centres has increased in recent years, with 129 centres providing such services, additional steps should be taken to reinforce outpatient services within general hospitals and reduce dependency on hospital care. There should be a shift in mental health services and public investments in the community, with initiatives grounded in human rights and modern principles of mental health policy and based on quality services and the empowerment of users.

123. Moreover, Algeria should move towards the implementation of the Convention on the Rights of Persons with Disabilities, which implies, first, moving away from a medical model with excessive emphasis on medical diagnosis and abandoning old-fashion practices leading to violations of people's rights based on diagnosis, treatment and medical necessity, as well as to stigmatization and discrimination.

124. For example, after they have been evaluated by medical doctors and psychologists, children with moderate and severe levels of developmental disabilities are referred to care centres which are under the jurisdiction of the Ministry of National Solidarity, Family and Women. The fact that the education of those children is not within the realm of the Ministry of National Education could be considered as a violation of their right to education. All children, including children with disabilities, should be enrolled in the mainstream school

[43] Ibid.

[44] See www.who.int/mental_health/publications/action_plan/en/.

[45] WHO Mental Health Atlas 2005, p. 54.

system and individual educational plans should be developed to appropriately address the level of development of each child.

V. Conclusions and recommendations

125. **Significant progress has been made over the past decades in Algeria with respect to the enjoyment of the right to health and there are good opportunities for its progressive realization. However, the authorities need to step up their efforts to address certain normative, structural and systemic issues to make sure that no one is left behind.**

126. **The right to health should be promoted and protected through access to health services, supplies and facilities, which should be available, affordable, appropriate and of good quality. The right to health can only be fully realized through the enjoyment of the underlying and social determinants of health, which requires the design and implementation of cross-sectoral policies and programmes that focus not only on life-saving biomedical interventions but also on broader socioeconomic, cultural and environmental factors.**

127. **Health policies or programmes should be guided by a human rights-based approach with strong emphasis on the principles of equality and non-discrimination, transparency, participation and accountability. Issues relating to the right to health would be better addressed through intersectoral policies with horizontal approaches that promote the effective use of primary care and incorporate the concerted efforts of all stakeholders.**

128. **The Special Rapporteur recommends that the Government of Algeria:**

(a) **Consider withdrawing all declarations and reservations to international human rights treaties; ratify the Optional Protocols on individual complaints procedures; and extend a standing invitation to the special procedures of the Human Rights Council;**

(b) **Strengthen the health-care system and guarantee adequate, equitable and sustainable financing by maintaining or increasing national budget allocations for health; and continue improving access to and the capacity of health structures in remote regions, with particular focus on primary care and the role of general practitioners;**

(c) **Ensure that a solid health information system is in place to generate quality national data and statistics to analyse gaps and design, implement, review and assess policies;**

(d) **Invest in nationally led evaluations of health policies and programmes; and establish independent mechanisms to monitor the performance of the health system;**

(e) **Address maternal and neonatal mortality and morbidity, including by launching a maternal death audit system and a reference guide on obstetric care and referring to the technical guidance on the application of a human rights-based approach to reducing and eliminating preventable maternal and under-five mortality and morbidity (A/HRC/21/22 and A/HRC/27/31);**

(f) **Respect, protect and realize the right to health of women and girls by removing barriers to their sexual and reproductive rights; ending the criminalization of abortion and ensuring access to abortion services; and providing sexual and reproductive health information, services and goods, in particular comprehensive, age-sensitive and inclusive sexual education in secondary schools;**

(g) **Ensure comprehensive protection for women against all forms of violence by addressing, without delay, the remaining gaps in legislation and in practice in order to ensure substantive equality and uphold their right to health and related rights;**

(h) **Protect children, adolescents and youth from all forms of violence and promote their health, well-being and autonomy by creating conducive environments and services and ensuring their meaningful participation in all decisions affecting them, particularly in the areas of mental health, sexual and reproductive health rights, and drug and substance use;**

(i) **Establish an independent national institution for the promotion and protection of children's rights with the mandate and resources necessary to enable it to perform its functions in consultation with key stakeholders;**

(j) **Remove the legal provisions criminalizing and stigmatizing people living with HIV/AIDS, including provisions in the Penal Code, and remove the requirement of a premarital medical certificate;**

(k) **Guarantee non-discrimination against people living with HIV/AIDS in the health-care sector by ensuring that health services, goods and information are available, accessible, acceptable and of good quality for all key populations and that the health workforce is properly trained and equipped;**

(l) **Promote a non-punitive approach to drug use policies and programmes outside the criminal justice system and expand pilot services for people who use drugs, based on scientific evidence and with full respect for their dignity and rights;**

(m) **Follow the guidance of the Committee on the Rights of Persons with Disabilities with regard to children and adults with psychosocial and intellectual disabilities;**

(n) **Adopt or favour mental health policies and services with a view to mainstreaming them in the general health system and community support services, and ensure the availability of psychotropic medications as well as psychosocial intervention for children and adults in need;**

(o) **Launch a gradual comprehensive reform of the mental health-care system to optimize investments and move away from excessive reliance on hospitals and inpatient care to community-oriented services based on the principles of non-discrimination, participation and respect for the dignity and rights of the users of such services.**

United Nations A/HRC/35/21/Add.2

General Assembly

Distr.: General
28 April 2017

Original: English

Human Rights Council
Thirty-fifth session
6-23 June 2017
Agenda item 3
Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his visit to Croatia

Note by the Secretariat

Pursuant to Human Rights Council resolution 33/9, the Secretariat has the honour to transmit to the Human Rights Council the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his visit to Croatia, which took place from 28 November to 6 December 2016.

As the newest member of the European Union, Croatia has made progress regarding the realization of the right to health, in particular by strengthening primary and specialized health care and investing initial efforts in necessary reforms to mental health care. The Special Rapporteur encourages the Government to advance further by developing policies guided by a human rights-based approach, in line with the 2030 Agenda for Sustainable Development (General Assembly resolution 70/1), avoiding retrogressive measures and paying particular attention to groups in the most vulnerable situations, including women, children, people on the move, national minorities, persons with intellectual, cognitive and psychosocial disabilities and older persons. The report addresses challenges and opportunities and makes a number of recommendations recalling the need to use financial resources in a transparent manner and in full compliance with international human rights.

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Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his visit to Croatia*

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* Circulated in the language of submission only

I. Introduction

1. The Special Rapporteur visited Croatia from 28 November to 6 December 2016 at the invitation of the Government. The purpose of the mission was to ascertain, in a spirit of cooperation and dialogue, national endeavours to implement the right to health, measures taken for its successful realization, and the obstacles encountered.

2. The Special Rapporteur met with high-ranking government officials from the Ministries of Foreign and European Affairs; Health; Demographics, Family, Youth and Social Policy; Finance; Science and Education; and Labour and the Pension System, and from the Offices for Gender Equality, Human Rights and Rights of National Minorities and the Office of the Agent of the Republic of Croatia before the European Court of Human Rights. He also met with members of the parliament and the Constitutional Court, as well as with the Ombudswomen and the Ombudspersons for children, persons with disabilities and for Gender Equality. In addition, meetings were held with representatives of civil society, international organizations and United Nations entities.

3. The Special Rapporteur visited health facilities, a secondary school and a community-based facility for persons with psychosocial disabilities, a reception centre for asylum seekers, a Roma settlement and a drug dependence centre, in Zagreb, Osijek, Vukovar and Split.

4. The Special Rapporteur is grateful to the Government of Croatia for its invitation and outstanding cooperation prior to and during the visit. He appreciates the important support provided by the United Nations in the country, including the United Nations Development Programme, the World Health Organization (WHO), the Office of the United Nations High Commissioner for Refugees (UNHCR), the United Nations International Children's Emergency Fund and the International Organization for Migrants.

II. Framework of the right to health in Croatia

A. Background

5. After attaining independence from the Socialist Federal Republic of Yugoslavia in 1991, Croatia successfully joined the European Union in July 2013. The process involved the overall revision of, and amendments to, approximately 680 pieces of legislation, which inter alia brought improvements in terms of the human rights framework, including a strengthened role of the Ombudsperson.

6. In the health-care sector, accessing the European Union required the normative and institutional framework to be harmonized and relevant European Union regional strategies (i.e., the European Commission health strategy) became immediately applicable.[1]

7. The current health-care system maintains the pre-1991 principles of universality and solidarity with elements from the various reforms that the sector has undergone owing to, inter alia, the process of independence and the global financial crisis of 2008. Thus, one public entity, the Croatian Institute for Health Insurance, has now consolidated previously separate insurance schemes (for employees, farmers and artisans and the self-employed), absorbing most of the health-care budget. Some private providers are also active in certain areas.

8. The share of the gross domestic product (GDP) allocated to the health sector has gradually increased since the 2000s, reaching 6.7 per cent of GDP in 2015; however, it has

[1] See European Observatory on Health Systems and Policies, "Croatia: Health system review", *Health Systems in Transition*, vol. 16, No. 3 (2014), p. 21. Available from www.euro.who.int/__data/assets/pdf_file/0020/252533/HiT-Croatia.pdf?ua=1.

not yet reached the levels of most European Union countries (on average 9.5 per cent).[2] Within the health sector alone, the proportion of public expenditure decreased between 1995 and 2012, but continues to be high compared with most countries in the European Union,[3] showing the continued priority of the sector on the national agenda.

9. Croatia made good progress with regard to all indicators linked to child mortality (Millennium Development Goal 4), under-5 mortality rate notably decreased from 12.8 deaths per 1,000 in 1990 to 4.5 per 1,000 in 2013. Advances have also been reported for some indicators linked to maternal health (Millennium Development Goal 5), in particularly the maternal mortality rate, which decreased from 10 per 1,000 in 1990 to 8 per 1,000 in 2015. The Special Rapporteur regrets, however, that information on other indicators for Millennium Development Goal 5 is not available, notably regarding contraceptive prevalence rates and unmet needs for family planning. Progress has also been achieved on indicators linked to Millennium Development Goal 6, in terms of tuberculosis incidence, prevalence, death rate per year, detection and treatment.[4]

10. Future endeavours should involve investment in rights-based approach policies, in line with the Sustainable Development Goals. Croatia should use the historic opportunity presented by becoming a European Union member and the global adoption of the 2030 Agenda to further advance the right to health. Additional progress could be achieved on issues related to the Millennium Development Goals that remained underreported and are now linked to the new global goal, Sustainable Development Goal 3.7 on universal access to sexual and reproductive health-care services. Action in this regard will be strengthened by the effective implementation of the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). Further issues related to the Millennium Development Goals that could still be advanced relate to certain universal health coverage indicators (Sustainable Development Goal 3.8) and to mental health (Sustainable Development Goal 3.4).

11. European Union structural funds should be devoted to developing rights-based health-care policies and services and should be used in a transparent manner in full compliance with universal human rights principles.

B. Normative and institutional framework

12. Croatia has ratified most of the international human rights treaties.[5] Between 2014 and 2015, it underwent reviews by the Human Rights Committee, the Committee on the Elimination of Discrimination against Women, the Committee on the Rights of the Child and the Committee against Torture). While Croatia has been a party to the Covenant on Economic, Social and Cultural Rights since 1992, its second periodic report to the Committee is currently overdue. In October 2016, Croatia was elected a member of the Human Rights Council for 2017 to 2019, with the possibility of re-election for a second consecutive term.

13. In 2003, Croatia extended a standing invitation to the special procedures of the Human Rights Council, and the Special Rapporteur on the right to health is the fifth mandate holder to visit the country since then. Croatia underwent the universal periodic review process in 2013 and 2015 and the country's next review is scheduled for May 2020.

14. At the regional level, Croatia is a party to the European Convention on Human Rights, the European Social Charter and its Additional Protocol and the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or

[2] Ibid., pp. 51-59, and European Commission, "Country report Croatia 2017", p. 53. Available from https://ec.europa.eu/info/file/96682/download_en?token=k-4wwF_K.

[3] In 2013, 17.6 per cent of the total State budget was allocated to health care: see European Observatory on Health Systems and Policies, "Croatia: Health system review", pp. 51-59.

[4] Millennium Development Goal data. Available from http://mdgs.un.org/unsd/mdg/Data.aspx.

[5] With the exception of the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families and pending ratification of the Convention for the Protection of All Persons from Enforced Disappearance, signed on 6 February 2007.

Punishment. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment has visited the country on four occasions, most recently in 2012, and has issued recommendations regarding the right to health, notably in relation to health care in prisons and in psychiatric institutions. The European Court of Human Rights has also dealt with cases regarding, inter alia, inhuman or degrading treatment towards persons with psychosocial disabilities and adequate or inadequate support for, or the deprivation of, legal capacity of persons with intellectual, cognitive or psychosocial disability resulting in human rights violations.[6]

15. Nationally, the right to health has been enshrined in the Constitution (current art. 59) since its promulgation in 1990, together with relevant rights, including informed consent (art. 23), rights to life (art. 21), to suitable life (current art. 63), healthy life (current art. 70) and the rights to equality and non-discrimination (arts. 1, 3, 14, 15 and 17). Pursuant to current article 59 "everyone shall be guaranteed the right to health care in conformity with the law".[7]

16. The most important legal acts governing the right to health are the Health Care Act (2008) and the Mandatory Health Insurance Act (2013).[8] The former regulates the organization and provision of health care, rights and obligations of users and the responsibilities of health-care institutions at different levels; establishing the principles for their monitoring. The Mental Health Insurance Act is explained below.

17. Specific areas are regulated in other acts, including the Patients' Rights Protection Act, the Medical Practice Act, the Pharmacy Act, the Nursing Act and the Dental Care Act; the Midwifery Act; the Physical Therapy Activities Act, and the Act on the Health Care Technical Services. The quality of health-care services is regulated in the Act on Quality of Health and Social Care and the provision of voluntary health insurance is governed by the Voluntary Health Insurance Act.

18. The national human rights institution is the Office of the Croatian People's Ombudsman. It was established in 1992 and over the years has progressively been assigned additional responsibilities. At present, it functions as a national human rights institution, central equality body and national preventive mechanism.[9] In 2008 and 2013, the Ombudsman was accredited "A" status by the Sub-Committee on Accreditation of the then International Coordinating Committee,[10] in compliance with the principles relating to the status of national institutions for the promotion and protection of human rights (Paris Principles). The Office, under the Ombudsman Act of 2012, examines human rights complaints and submits annual reports to the parliament.

19. Complaints currently dealt with by the Ombudsperson come under 17 discriminatory grounds as listed in the Anti-discrimination Act (art. 1, (1)),[11] exempting gender, gender identity and expression and sexual orientation; discrimination against children; and disabilities, as these are dealt with by specialized ombudspersons for gender equality and for children (both introduced in 2003) and for persons with disabilities (established in 2008), respectively.

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[6] See European Court of Human Rights, press country profile: Croatia. Available from www.echr.coe.int/documents/cp_croatia_eng.pdf.

[7] See Constitution of the Republic of Croatia 2010 (consolidated text), Zagreb, 6 July 2010. Available from www.sabor.hr/fgs.axd?id=17074.

[8] See European Observatory on Health Systems and Policies, "Croatia: Health system review", pp. 15 and 17-18.

[9] See European Network of Equality Bodies, brief profile, Office of the Ombudsman — Croatia. Available from http://adsdatabase.ohchr.org/IssueLibrary/Office%20of%20the%20Ombudsman%20-%20Croatia.pdf.

[10] In 2016, the International Coordinating Committee changed its name to the Global Alliance of National Human Rights Institutions. See national human rights institutions accreditation status chart at www.ohchr.org/Documents/Countries/NHRI/Chart_Status_NIs.pdf.

[11] Anti-discrimination Act, July 2008. Available from www.minoritycentre.org/sites/default/files/antidiscrimination_law_croatia.pdf.

20. Since 2011, the Government has been obliged to monitor and report on the fulfilment of recommendations issued by the Ombudsperson.[12]

C. The national health-care system[13]

21. With a population of about 4.3 million, life expectancy at birth in Croatia (81 years in 2014) has progressively increased; although it remains slightly below the European Union average (83.6 years).[14] As in many European countries, the population in Croatia is ageing, requiring adjustments in the health-care system. Furthermore, new public health concerns have emerged, including overweight and obesity, together with concerning trends in low levels of physical activity, for which rates continue to decrease. More than half of men and women are overweight and one fifth of the population is obese.[15]

22. While alcohol consumption, smoking and unhealthy diet show some positive trends,[16] official information shows that drug dependence has steadily increased,[17] and public mental health continues to be an area requiring attention. In 2015, mental and behavioural conditions were one of the most common reasons for users to seek hospital treatment.[18]

The sector in transition

23. Since the process of independence, the health-care sector has faced financial difficulties which have been tackled since the 1990s with various austerity measures. Between 2008 and 2011, health-care reforms aimed at financial stability were undertaken but neither underwent proper consultation with the main stakeholders, nor were always combined with thorough implementation plans and thus resulted in partial implementation.[19] Subsequent reforms have been focused on achieving cost-effectiveness in the hospital sector.

24. According to the European Commission,[20] arrears in the health sector in combination with inadequate administrative capacity and strategic planning have hindered the absorption of European Union funds. Health-related current arrears are largely linked to the organization and structure of hospitals, which are concentrated in metropolitan areas and mainly managed through a funding and reimbursement model, on the basis of advance payments. In addition to the hospital reforms needed, the European Commission has stressed the need to reduce pharmaceutical expenditure and draw up concrete plans to address accumulation of arrears.

25. In 2015, public consultations to reform the Health Care and Mental Health Insurance Acts to introduce cost-reduction measures triggered a debate about their impact on the quality of health-care services, which could be diminished, disproportionately affecting people in the most vulnerable situations. Additional issues raised included the potential disparities that could result from medical doctors working simultaneously in the public and

[12] See universal periodic review of Croatia, national human rights institution joint coalition report, 2nd cycle, September 2014. Available from www.ohchr.org/Documents/Issues/OlderPersons/NGOAA/NHRI_Croatia.docx.

[13] See European Observatory on Health Systems and Policies, "Croatia: Health system review".

[14] See Eurostat, Statistics explained, File: Life expectancy at birth, 1980-2014 (years). Available from http://ec.europa.eu/eurostat/statistics-explained/index.php/File:Life_expectancy_at_birth,_1980%E2%80%932014_(years)_YB16.png.

[15] See European Observatory on Health Systems and Policies, "Croatia: Health system review", p. 10.

[16] Ibid., pp. 10-13.

[17] See Office for Combating Narcotic Drug Abuse, "National strategy on combating drug abuse in the Republic of Croatia for the period 2012-2017, p. 7. Available from www.emcdda.europa.eu/system/files/HR_National%20strategy_en.pdf.

[18] Croatian Institute of Public Health, *Croatian Health Statistics Yearbook 2015* (Zagreb, 2016), p. 21. Available from www.hzjz.hr/wp-content/uploads/2017/02/Ljetopis_2015_IX.pdf.

[19] See European Observatory on Health Systems and Policies, "Croatia: Health system review", pp. 123-129.

[20] European Commission, "Country report Croatia 2017", p. 54.

private sectors. Owing to lack of compliance of the consultations process with the Regulatory Impact Assessment Act and the Act on the Right to Access to Information, the 2015 reform was partly interrupted.[21]

26. The Special Rapporteur recalls that any reform in the health-care system should include the meaningful participation of all major stakeholders in policy decision-making, as well as independent monitoring and review of outcomes and be based on population health status indicators and the performance of the health system. Implementation of the principles of accountability, participation and transparency allows health-care systems to be self-critical and prevents the ineffective use of resources and corruption within the system.

Universal coverage and affordability

27. The Ministry of Health is the main authority responsible for health policy, planning and evaluation; public health programmes, and the regulation of investments. Health-care services in Croatia are organized as a network of public health institutes with one national institute, managed by the Ministry of Health, and 21 in each county, managed by the counties. The national institute coordinates and supervises national institutions and is responsible for gathering, analysing and publishing statistics. Counties develop local plans, collect local statistics and participate in the formulation and implementation of local plans.

28. Health-care institutions (university hospitals, national institutes and specialist clinical hospitals) may only be established by the Ministry of Health. Four university hospital centres, in Zagreb, Split, Rijeka and Osijek, provide training and education for future medical doctors and conduct scientific research. Other facilities, including general and specialized hospitals; primary health centres; county institutes of emergency medicine and public health; outpatient clinics; spas; facilities providing home and palliative care; and pharmacies, may be established by each county.

29. Long-term health care in Croatia mainly concerns older persons and persons with intellectual, cognitive or psychosocial disabilities and is mostly organized through the social welfare system and provided in institutional settings. Since 2013, the Social Welfare Act has sought to progressively withdraw institutional long-term care for older persons by keeping them at home with their family; promoting their social inclusion and improving their quality of life through non-institutional services and volunteering.

30. Through the Mandatory Health Insurance Act all Croatian citizens and residents have the right to health. The single insurer in this scheme is the Croatian Institute for Health Insurance, established in 1993 to provide universal health insurance coverage to the whole population, based on a benefits package defined under the Mental Health Insurance Act scheme. Basic health-care services are provided according to users' needs.

31. The Croatian Institute for Health Insurance has an important role in defining basic health services, performance standards and the prices of services covered under the Mental Health Insurance Act scheme. It is also responsible for relevant social security allowances and benefits, including sick leave compensation and maternity-related benefits, and is the main provider of supplemental health insurance.

32. In 2013, most of the Government's health-care budget (91 per cent) was allocated to the Croatian Institute for Health Insurance, which is also funded by contributions from employees, the self-employed and farmers. Full contributions are paid by only about a third of the population and certain groups are completely exempt, including those under 18 years of age, students, the military, war invalids, unemployed persons, persons with disabilities and blood donors upon reaching a predetermined donation amount. These groups are financed from the payroll of contributing users and from transfers by both government and county budgets. Contributions represent 76 per cent of the Institute's total income.

[21] See "Annual report of the Ombudswoman of the Republic of Croatia" (31 March 2016), p. 78. Available from http://ombudsman.hr/attachments/article/1016/Annual%20Report%20of%20the%20Ombudswoman%20of%20Croatia%20for%202015.pdf.

33. Some health-care services under the Mental Health Insurance Act are subject to co-payments and the relevant amounts are defined according to the users' ability to pay. In addition, supplemental health insurance is available and is purchased individually and on a voluntary basis, from either the Croatian Institute for Health Insurance or private insurers, mostly to cover user charges in the Mental Health Insurance Act system. Persons with disabilities, human organ and blood donors, students and low-income persons have the right to free supplemental health insurance from the Institute.

34. In Croatia, the right to affordable health care has been impacted since 2003, with increases in co-payments for practically all services and the introduction of service rationing. However, groups in vulnerable situations have been financially protected through full coverage and free supplemental health insurance. In addition, co-payments, usually paid through the supplemental insurance, cannot exceed a fixed limit.

Access to health-care services

35. Users' regular first point of contact with the health-care system is the general practitioner at the primary care level. Users may choose their own general practitioners and dentists, as well as gynaecologists and paediatricians, as applicable. All of them are categorized as general practitioners in Croatia. There must be at least one primary health-care centre in each county and three in Zagreb. Users may also choose their specialist and hospital, and are not restricted to their place of residence in this.

36. As noted by WHO[22] and observed by the Special Rapporteur during the visit, there is a tendency to skip the primary level to search for specialized care, under an overall misconception that primary care may not provide the necessary attention and quality of care. The Special Rapporteur stresses that primary health care is the cornerstone and the means of sustainability of any health-care system, which functions more effectively and rationally when the majority of cases (up to 80 per cent) are dealt with at the primary level. This allows for the accumulation of resources to finance expensive treatments for severe and complex medical cases at the specialist level.

37. Solid primary health-care services which are trusted by the people are crucial in rationalizing the resources allocated to specialist medicine and to costly inpatient health care. A number of studies show that health systems can improve equity, efficiency, effectiveness and responsiveness by strengthening primary care while decreasing the unnecessary use of specialists and hospital care.[23]

38. Croatia needs to strengthen primary health care, both in quantity and quality, for the early detection and treatment of mild forms of illnesses, before they reach the stage at which they require specialist care. An optimal balance between general practitioners and specialists should be sought by providing outpatient specialist care which backs up the general practitioners. Specialists should receive patients referred from general practitioners and consult with them on the cases, notably regarding treatment for non-complicated cases. Otherwise, specialist care risks saturation. Where physical health is concerned, the majority of health conditions are mild cases that should be managed by general practitioners.

39. To achieve a balance between general practitioners and specialists, the capacities and competencies of general practitioners and their teams (nurses, social workers and assistants) should be improved, through continuous learning programmes and incentives to consolidate their position as "gatekeepers" of the system.

40. As noted by the European Commission, strengthening primary health care in Croatia would bring about reductions, not only in the number of referrals to specialists, but in the cost of specialist and hospital treatments. The Commission has stressed the over-reliance on hospital services, due to the partial development of primary care in Croatia, recommending a reorganization of the current unequal distribution of hospitals to promote fiscally

[22] See European Observatory on Health Systems and Policies, "Croatia: Health system review", p. 97.

[23] See M. Seychell and B. Hackbart "The European Union Health Strategy — Investing in Health", *Health Reviews*, vol. 35, No. 1, p. 7.

responsible hospital management and gain sustainability.[24] WHO has further noted the lack of care pathways for users which would help to change the practice of skipping the primary level to look for a specialist.[25]

Challenges with regard to access to health care and informed consent

41. While unmet needs for medical examination in Croatia are below the European Union average, inequalities in accessing health care have increased since 2012, notably due to distance-related challenges linked to the country's geography and large number of islands (over 1,000). During his visit, the Special Rapporteur was briefed about the unequal access to health care faced in particular by older persons, children and pregnant women in rural areas, smaller towns and islands with poor traffic connections to large cities. He was also briefed about promising initiatives to address challenges with a strategic framework for islands that would improve connections by the use of speed boats, in addition to helicopters, for medical doctors in large cities, to increase the frequency of consultations in remote locations. He trusts that these initiatives will be implemented.

42. Health-care complaints dealt with by the Ombudsperson increased from 64 in 2012 to 178 in 2015.[26] Complaints in 2015 included issues linked to accessing certain health-care services such as therapies for rare diseases, problems in making doctor's or treatment appointments, long waiting lists and the overall quality of health-care services, treatments and facilities.[27]

43. During the visit, the Special Rapporteur was consistently informed that the most pressing challenges to access to the right to health in Croatia were the long waiting lists for medical procedures and the limited access to good quality medical treatments. Both issues seem ultimately to compel users who can afford it to turn to private providers, although, generally speaking, the same doctors are employed simultaneously in both the public and private sectors. Private services seem to allocate more time for users and to provide more information on treatments, their effects and options, giving rise to discrimination against users who cannot afford private services and/or are less educated and do not get adequate information on their health and treatments owing to the lack of time allocated in public services to provide information about them.

44. The issue of long waiting lists was partially dealt with in 2015 through some programmes for specific medical procedures, which were successful in certain cases.[28] However, the overall issue of long waiting lists seems to be far from being sufficiently addressed, as illustrated by cases of rehabilitation treatment linked to surgery which can take several years to be approved and actually provided.

45. Lastly, while the rights to be informed on alternative treatments and to consent to or refuse treatment are protected by the national framework,[29] the Special Rapporteur ascertained that informed consent seems not to be well understood by health-care personnel. In practice, informed consent has become a simple formality, whereby users are often requested to sign the relevant consent form in the waiting room before meeting the doctor. In addition, it was reported that three out of five women in Croatia do not participate meaningfully in decisions concerning labour and birth.

46. To address these issues appropriately, official statistics on waiting lists and proper assurances of users' consent should be produced, and result-assessments of 2015 programmes should be conducted. All measures aimed at addressing the issues should take account not only of accessibility and availability, but also of the quality of services.

[24] See European Commission, "Country report Croatia 2017", p. 54.
[25] See European Observatory on Health Systems and Policies, "Croatia: Health system review", p. 97.
[26] See "Annual report of the Ombudswoman" (2016), p. 8.
[27] Ibid., p. 126.
[28] Ibid., p. 125.
[29] See European Observatory on Health Systems and Policies, "Croatia: Health system review", p. 45.

III. Health care in institutions and the way forward

A. Mental health framework

47. At the international level, mental health is increasingly taking priority, as reflected by recent discussions at the Human Rights Council[9] and at WHO headquarters, where the issue has recently been addressed as a priority. The Committee on the Rights of Persons with Disabilities has raised the issue of the need to fully guarantee the exercise of all human rights, including the right to health, to persons with disabilities and especially those with intellectual, cognitive and psychosocial disabilities.

48. Croatia was among the first countries to ratify the Convention on the Rights of Persons with Disabilities in August 2007 and, during the visit, the Special Rapporteur was encouraged at the new legal framework and measures aimed at addressing many of the recommendations of the Committee on the Rights of Persons with Disabilities. In 2012, in amendments to the electoral law, the right to vote was granted to 18,000 people with intellectual, cognitive or psychosocial disabilities who had been deprived of their legal capacity for decades. Further steps include reforms to the Social Welfare Act with regard to deinstitutionalization, as explained in the following section and the new Family Act which, inter alia, abolishes full guardianship and establishes a five-year deadline for reviews of all court decisions on deprivation of legal capacity, combining the concepts of mental and legal capacity and introducing the concept of supported decision-making.

49. The Law on the Protection of Persons with Mental Disorders (2015), which replaces an earlier law on mental health, now provides for stronger mechanisms and guarantees to progressively reduce involuntary institutionalization, including the requirement, under judicial control, for the written consent of a legal guardian or trusted person in the case of non-consensual hospitalization of persons with intellectual, cognitive and psychosocial disabilities "unable" to give consent. The law also introduces the possibility of independent supervision over the decisions of legal guardians.

50. The Ministry of Health is the body primarily responsible for mental health care through national strategies. The strategic plan for the development of public health includes the goals of the promotion of mental health, prevention, social inclusion and rights protection. Other policies with elements of mental health include deinstitutionalization plans in the social welfare system and provisions to include mental health themes at preschool and primary and secondary school levels.

51. While mental health care is provided in Croatia at the primary level (general practitioners, school medical specialists, psychiatrists and professionals in mental health centres and public health institutes), the secondary level (mental health professionals, mainly psychiatrists) and the tertiary level, the mental health system is still too focused on psychiatric hospitals. Since 1991, inadequate attention has been paid to the development of outpatient mental health services at the community level, which has led to an overreliance of the system on inpatient services, mainly provided at psychiatric hospitals. To illustrate, mental health conditions are one of the most common reasons for hospital treatment and nearly one in four days of hospital treatment is used to treat a mental condition.[10]

B. Deinstitutionalization

52. Deinstitutionalization has been a key policy priority for the Government for some years, but mainly within the social welfare sector, with low participation by the health sector. In 2011, the Ministry of Demographics, Family, Youth and Social Policy formulated the National Plan for Deinstitutionalization and Transformation of Social Welfare Homes

[9] In its resolution 32/18, the Human Rights Council requested the United Nations High Commissioner for Human Rights to prepare a report on mental health and human rights. The report (A/HRC/34/32) was submitted to the Council at its thirty-fourth session.

[10] Croatian Institute of Public Health, *Croatian Health Statistics Yearbook 2015*, p. 22.

2011-2018. Two years later, several institutions began the process of finding homes for persons previously institutionalized. In 2014, the Plan was revised to, inter alia, integrate and operationalize funds from the European Union. The Plan is aimed at, inter alia, transforming former homes into community services, developing community support and integrating users into the community.

53. The Special Rapporteur learned that, by 2016, through deinstitutionalization, approximately 600 persons had been moved out of institutions to community-based services. However, he also learned that the same number of people have since been institutionalized in hospitals through the health-care system. While commendable efforts by the social welfare system are directed at reducing reliance on institutional care, stigma and discrimination by decreasing the number of people living in institutions, the health-care system, largely based on treatment in psychiatric hospitals with mainly biomedical interventions, continues to "feed" the institutional care system. This shows the lack of an effective "gatekeeping" policy in the health-care sector and, above all, the urgent need for coordination between the social welfare and health sectors.

54. The capacity in psychiatric institutions continues to escalate, as shown by the increasing number of psychiatric beds[17] and the increasing amount of financial resources directed at enhancing hospital infrastructure, a situation that was observed by the Special Rapporteur in his visit to a psychiatric hospital in Zagreb which was in the process of expanding, with the construction of a new building for forensic patients.

55. On the other hand, Croatia is one of the first countries to have invested in community-based pilot projects to end institutionalization. One good practice is the work carried out at the "I am just like you" Centre in Osijek. The Special Rapporteur visited the Centre and was pleased to confirm the full inclusion of people with psychosocial disabilities in society, living in ordinary apartments, in small groups, with minimal regular support from Centre staff. The Special Rapporteur strongly recommends that this good practice be replicated elsewhere in Croatia and in other countries. This experience shows that transforming institution-based services into community-based services is beneficial for persons with psychosocial disabilities and for society at large. It also shows that, where there is a will, it is possible to end the sad legacy of institutional care.

56. Successful pilot projects to integrate persons with psychosocial disabilities into the community, such as that in Osijek, have not been taken seriously as making a real difference in the Croatian mental health system, its funding or decision-making, which remain focused on large inpatient and residential psychiatric institutions. The Ombudsperson for persons with disabilities has consistently stressed the need to reorganize mental health services and to move away from the model of recurrent hospitalization towards more outpatient support and treatment and community-based services.

57. The Special Rapporteur was informed that approximately 4,200 people with intellectual, cognitive and psychosocial disabilities still live in institutional care, deprived of their liberty and unable to fully enjoy their rights on equal terms with other members of society. Of those, persons with psychosocial disabilities are the largest group institutionalized in Croatia.

58. Croatia should develop policies strongly oriented towards addressing the needs and rights of service users, as opposed to the needs of the existing service infrastructure. In this respect, Croatia could use the unique opportunity represented by the availability of European structural support funds to continue transforming the mental health-care system in an enhanced manner. Any health-care reform demands additional resources owing to the time needed for the new system to be operational. There will be a period when the old ineffective system and the rights-compliant reformed system should be running simultaneously, as it is not possible to implement a radical programme of closures of residential institutions and psychiatric hospitals before alternative services are well developed and integrated into primary care, community care and general hospitals.

[17] See European Observatory on Health Systems and Policies, "Croatia: Health system review", pp. 93-94.

59. European Union structural funds should be directed at building up a modern rights-compliant system throughout Croatia, with services that prevent referrals both to psychiatric hospitals and to large residential institutions. Rights-compliant and cost-effective mental health-care systems require the relevant services to be integrated into community-based health and social services.[77] Segregated institutions and large psychiatric hospitals for long-term health care should no longer be supported or expanded in Croatia. Instead, rights-compliant services should be developed at the community level, based on a combination of necessary psychotropic medications, psychosocial rehabilitation, psychotherapy, professional and vocational rehabilitation and supported housing.

60. While this shift in policy and practice is yet to be fully implemented, the country has invested considerable efforts into this enterprise. Croatia has an exceptional opportunity to replicate throughout the country the laudable undertakings that have proven to be rights-compliant and effective. Each county in Croatia should develop a health and social care plan to implement the transformation towards outpatient primary mental health care and community-based services, so that there is no longer a need to rely on large psychiatric institutions.

61. The country's ambitious plan to become an inclusive society, as the Special Rapporteur was informed during his visit, should fully incorporate mental health reform that fully integrates people with intellectual, cognitive and psychosocial disabilities and older persons into society.

IV. Sexual and reproductive health rights

62. Progress on the right to health of women in Croatia includes advances in certain health indicators such as maternal mortality. A welcome development before the Special Rapporteur's visit was the announcement of the intention of Croatia to ratify the Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention), which Croatia had signed in January 2013. He trusts that ratification will soon take place.

63. Various challenges to women's realization of their right to health remain insufficiently addressed. The Special Rapporteur was able to observe that the concerns of the Committee on the Elimination of Discrimination against Women (see CEDAW/C/HRV/CO/4-5) remain valid to date and have, furthermore, been exacerbated by attempts to implement retrogressive measures, including the redefinition of marriage in the Constitution, which may limit women's right to access health care on the basis of their marital status, and a pending revision of the 1978 Act on Health Care Measures for Exercising the Right to a Free Decision on Giving Birth.

A. Maternal health care and women's rights during childbirth

64. Since 2010, Croatia has centralized birth and postpartum care in 31 maternity hospitals, closing down small maternity units which were reportedly working well. As a result, the distance between place of residence and maternity hospitals has increased, disproportionately affecting women on islands and in remote locations. Reports indicate that 52 per cent of women of childbearing age live outside cities with maternity hospitals and, in 2014, 2 per cent of births took place with the assistance of emergency teams on the way to hospital. However, there is a lack of more detailed official statistics on women living more than 30 km or 50 km from a maternity hospital and their access to health-care services.

65. As home birth is not regulated in Croatia,[78] the great majority of births take place in hospitals, attended by doctors with the assistance of midwives. Neither doctors nor

[77] WHO, "The World health report 2001 — Mental health: new understanding, new hope".

[78] European Parliament, "Petition No 1400/2014 by D. D. (Croatian) on an alleged breach of provisions on professional qualifications of midwifes of Directive 2005/36/EC in Croatia" (29 June 2016).

midwives may attend home births, except for accidental or emergency cases. This limits women's choice as to where to give birth. Consideration should be given to planned out-of-hospital births as an affordable and accessible option available to women so that they can make informed choices as to their delivery preferences. Women should not be deprived of medical assistance should they choose to give birth at home, and health-care personnel should be allowed to provide such assistance.

66. The Special Rapporteur was briefed about certain practices during labour and birth, very often employed without women's consent, sometimes even against their wishes, which in most cases remain undocumented. These include mandatory adoption of the supine position during the entire process of labour and birth, labours augmented with artificial oxytocin, routine enemas before giving birth, the extensive use of episiotomy; and the Kristeller manoeuvre: full-body pressure on the abdomen to attempt to speed up the delivery, sometimes associated with broken ribs, among other undesirable side effects. Women's privacy is not fully guaranteed, as hospital birthing rooms rarely have doors and, where they have, they tend to remain open.

67. With regard to medically assisted reproduction, while a new act of 2012 brought about improvements, the procedure is only available to heterosexual women and couples, while same-sex couples are explicitly excluded under the Law; single women may only have access to the procedure with proof of infertility, which is difficult to obtain in practice; and women aged 42 years and over can access private procedures only. Women who cannot afford the related costs are also left behind as only certain treatments are reimbursed by the Croatian Institute for Health Insurance and additional payments are required for the public notary, who must certify the relevant informed consent form. Medically assisted reproduction is reportedly the only health-care treatment in Croatia for which the consent form is not signed in a health-care facility.

68. The lack of official data regarding these issues hampers adequate assessment and the identification of appropriate measures.

B. Access to modern and emergency contraception

69. The use, availability and accessibility of modern contraception and reproductive services remain at a low level in Croatia and are excluded from coverage by the Croatian Institute for Health Insurance. In addition, updated data available on the area are insufficient. This hinders access and fosters misperceptions and lack of knowledge about these methods. Additional barriers relate to the relatively high price and inadequate availability of different types of contraceptives in the country.

70. Regarding emergency contraception, the Ombudsperson for Gender Equality has noted [9] that women who wish to purchase the brand authorized by the European Commission for sale without prescription are requested to answer a questionnaire, disclosing private information about their sexual behaviour and reproductive health which should be protected under their right to privacy (see Human Rights Committee, general comment No. 28 on equality of rights between men and women, para. 20). In Croatia, pharmacists can refuse to sell the contraceptive pill if they consider the answers to be unsatisfactory and must report the transaction to the woman's gynaecologist. Girls under 18 years of age are not allowed to buy the pill without third-party authorization by way of the required presence of a parent or legal guardian.

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[9] Available from www.europarl.europa.eu/RegData/etudes/STUD/2016/556931/IPOL_STU(2016)556931_EN.pdf.

[10] See European Commission, European network of legal experts in gender equality and non-discrimination, Country report – Gender Equality: Croatia 2010, p. 42. Available from www.equalitylaw.eu/downloads/556-2010-hr-country-report-gender.

C. The right to safe abortion

71. The 1978 Act on Health Care Measures for Exercising the Right to a Free Decision on Giving Birth establishes legal access to abortion for women up to the tenth week of pregnancy and with the approval of a commission for more advanced pregnancies in the following three cases: (a) pregnancy resulting from a crime, (b) to prevent damage to the woman's health or to save her life, and (c) serious congenital impairment of the fetus.[16] The Act also establishes that girls under the age of 16 require the consent of a parent or legal guardian, although, in practice, parental consent is reportedly requested for girls under 18 years of age.

72. In addition to the issue of third-party authorization, for some years the implementation of the Act has encountered various challenges, including its increasing cost, which is borne by the Croatian Institute for Health Insurance only in cases where abortion is necessary for medical reasons.[17] The Special Rapporteur was informed that the cost of abortion in five hospitals is above the country's net minimum salary per month.

73. In practice, access to safe abortion has been obstructed by the overuse of the legal provisions to deny it on the grounds of conscientious objection. Individual doctors are legally allowed to refuse diagnosis, treatment and rehabilitation on the basis of personal ethical, religious or moral beliefs and are required to promptly inform the user and make a referral to another appropriate medical professional.[18] The Special Rapporteur was further informed that while half of gynaecologists refuse to provide legal abortion in public hospitals on conscientious grounds, many of them offer the same service in their private practices in exchange for a fee. This calls into question the real grounds for the denial of abortion in public hospitals. Moreover, while legally only individual refusals are allowed, in practice refusals are exercised at the institutional level and, in some cases, as part of a hospital's policy.

74. Barriers to accessing public safe legal abortion services lead women to seek clandestine options, which put their integrity and health at risk and disproportionately affect women in situations of social exclusion and in remote areas who cannot afford or access other services. Failure to implement the law should be combined with appropriate sanctions and mechanisms to monitor its implementation. At present, there is no official data on the prevalence of conscience-based refusals, which prevents the development of effective measures to address these challenges.

75. The Special Rapporteur is concerned about announcements in October 2016 on the assessment and possible repeal of the Act on Abortion of 1978. Any legal measures that restrict existing core provisions in the protection of human rights constitute retrogressive measures in contravention of the relevant international framework.

D. Sexuality education

76. While sexuality education was introduced as part of the curriculum for health education in elementary and secondary schools, only two hours per year were allocated to the subject. Moreover, the delivery of the relevant module depends on the teacher concerned, as ascertained by the Special Rapporteur during his visit to a secondary school. Teachers often refuse to deliver sexuality education on the basis of arguments that are contrary to universal human rights that prevent children and adolescents from learning about gender equality and from making informed decisions about their bodies and sexuality, including about healthy sexual behaviours and the use of contraceptives.

[16] Act on Health Care Measures for Exercising the Right to a Free Decision on Giving Birth, Act No. 1252-1978 of 21 April 1978, art. 22.

[17] See European network of legal experts in gender quality and non-discrimination, *Country report — Gender Equality: Croatia 2016*, p. 42.

[18] Conscientious objections may be exercised by doctors as long as the doctor's refusal does not conflict with the rules of the medical profession and does not cause permanent damage to the user's health or life (see Medical Practice Act, art. 20).

Adolescent students who met with the Special Rapporteur expressed their need for more and better age-sensitive comprehensive sexuality education.

77. The Ombudsperson for Children has further noted the overall absence of systematic health education, such as education on sexually transmitted diseases, including HIV/AIDS, which should be provided through an increased number of lessons delivered by competent experts. Overall, teachers should be trained on health and sexuality education to enable them to deliver quality information to students, with the use of good quality teaching materials.

E. Other challenges

78. Remaining challenges in Croatia regarding women's right to heath include issues at work, assistance to victims of domestic violence and the current sociopolitical environment vis-à-vis women's rights.

79. While the Labour Act prohibits employers from asking questions about women's pregnancy plans and from denying, terminating or reassigning employment on account of pregnancy, available data indicate that many women have been asked at job interviews about their plans to have children; overlooked for promotion on account of being mothers; have not had their contracts extended owing to pregnancy or other parental obligations or have been discriminated against at some point in their careers or job searches on account of their parental obligations.

80. Additionally, maternity benefits are subject to employment status, putting women who are on part-time contracts at a disadvantage. After sick leave linked to pregnancy, maternity leave or parental leave, women on part-time contracts are considered to be unemployed and receive lower maternity or parental benefits, despite having worked before their maternity leave.

81. The Ombudsperson for Gender Equality has warned that women's participation in the workplace is undermined by the lack of adequate day care for preschool and school-age children. Costs, which vary considerably by region and parents' income, are another significant barrier.

82. Notwithstanding the remaining challenges, the Special Rapporteur was also apprised that Croatia provides, by international standards, one of the most generous sick leave and maternity compensation packages, which, according to some, could make the system open to abuse.[16] This all indicates a need for monitoring mechanisms to oversee the correct application of compensation packages with special attention to the implementation of legal provisions to protect women at work.

83. A different set of barriers regarding women's right to health relates to shelters and counselling centres for victims of domestic violence, which lack consistent and adequate funding. Legal reforms are necessary to effectively protect women from domestic violence, and to address remaining gaps in the implementation of the hate crime provisions of the Criminal Code, involving violence against lesbian, gay, bisexual and transgender people. The Special Rapporteur was informed about alleged violent and abusive acts by law enforcement officials, including insults, physical aggression, violations of victims' rights and rejection of complaints on insufficient grounds.

84. During his visit, the Special Rapporteur was able to observe at first hand a matter about which the Committee on the Elimination of Discrimination has consistently cautioned, regarding church-related organizations which appear to adversely influence policies concerning women's rights, thereby impeding the full implementation of human rights international treaties. Sexual and reproductive health services that are most needed by women, in particular young women, include access to safe, reliable and good quality contraception, comprehensive maternal health services, safe abortion and treatment for complications from unsafe abortion and prevention and treatment of sexually transmitted

[16] See European Observatory on Health Systems and Policies, "Croatia: Health system review", p. 52.

infections and HIV/AIDS (see E/CN.9/2014/4 and Corr.1, paras. 68-77). Poverty, low education levels, insufficient access to health services, gender discrimination and a lack of empowerment constitute barriers for women with regard to making the best informed choices about their sexual and reproductive health and the health of their children, giving rise to poorer health outcomes and higher risks (see A/HRC/27/31, para. 74).

85. Sexual and reproductive health rights are human rights. Retrogressive measures preventing access to safe abortion and contraceptives and hindering access to age-appropriate comprehensive sexuality education may amount to human rights violations (see Economic and Social Council, general comments No. 14 on the right to the highest attainable standard of health, para. 48, and No. 22 (2016) on the right to sexual and reproductive health, para. 38). Sexual and reproductive health rights also indicate that primacy should be given to women's and children's rights and not to the family unit. In this respect, the Special Rapporteur is concerned about the potential redefinition by the Constitutional Court of marriage as the union between a man and a woman, should this hinder proper access to sexual and reproductive health rights on the basis of marital status.

86. The Special Rapporteur noted strong opposition among policymakers and within society at large towards well-established standards, instruments and mechanisms for the promotion and protection of women's sexual and reproductive health rights. He urges all stakeholders to support policies based on universal human rights principles, including those concerning sexual and reproductive health, and to reject what could be seen as conspiracy theories, which promote patriarchal gender stereotypes and undermine the role of women and girls in society. These theories are detrimental to the enjoyment of all rights, including the right to health, in particular of women and children. The Croatian authorities must ensure full adherence to universal and regional human rights principles and standards which, if applied in a consistent manner, constitute the basis for the realization of the right to health and other rights.

V. Right to health of key population groups

A. Children

87. While there have been advances in some health indicators, notably child mortality, Croatia still faces challenges regarding children's health, including easy access to alcohol and tobacco, linked to a lack of compliance with relevant law.[87]

88. Additional well-documented challenges include the lack of, and difficulty of access to, certain health-care experts, including paediatricians, health-care specialists at schools and universities, speech therapists, psychologists, occupational therapists, nurses and social workers. For example, many paediatricians are close to retirement age, although enrolment into paediatric training programmes is decreasing. This is leading to an increased number of infant patients per primary care team, leaving insufficient quality time for preventive care, including for the screening and identification of children with developmental difficulties, which appear to be increasing.

89. A common concern for the ombudspersons for children and persons with disabilities relates to children's mental health and particularly that of children with autism. The Croatian system seems to lack adequate capacity, with insufficient health-care personnel and facilities. A large number of children with mild to moderate autism are not identified until they reach school age, indicating the need for a coordinated package of early childhood interventions in or close to the areas where they live.

90. While an important step was taken by including early childhood interventions as a service in the Social Welfare Act in 2011, the State has yet to create the conditions for the implementation of such provision. According to official data, in 2013 there were 4,800

[87] Croatian Ombudsperson for Children 2014. Report on her work, March 2015, p. 17. Available from http://www.dijete.hr/en.html.

children who required such services, but only 641 (13 per cent) had access. Early childhood interventions are provided through a small number of facilities located in or around the capital and at a high cost for average parents. Only one institution in Croatia specializes in early childhood interventions, but this is understaffed and therapy is often discontinued after the age of 3.

91. A more systematic approach, which integrates health, education and social services, is needed for the early screening and detection of developmental challenges in young children at the primary health-care level. This requires the introduction of appropriate, standardized, scientifically reliable and valid instruments and a family-centred approach to monitoring child development, with the family as an active partner. Primary health-care workers should have access to professional educational development and protocols and guidelines should be developed for the cross-sectoral collaboration of health, education and social services in the assessment, diagnostic and early intervention services for children with developmental challenges and risks.

92. With regard to breastfeeding, relevant advances include the adoption of the national programme for protecting and supporting breastfeeding in May 2015 and designation of all 31 maternity hospitals as "baby-friendly". However, while the rate of early initiation of breastfeeding is high (80 per cent), its duration has not significantly increased, in part owing to lack of awareness of the benefits of exclusive breastfeeding and lack of adequate support services for women.

93. The Special Rapporteur gathered information on the strong support of most paediatricians in Croatia for introducing solids to babies as early as 17 weeks. He also learned of the counterproductive influence of companies that market breast milk substitutes, which is evident in their regular sponsorship of conferences for paediatricians and nurses, which is not perceived as constituting a conflict of interest in the country.

94. Breastfeeding is a human right that should be protected and promoted. Women should be supported in their choice and ability to breastfeed their infants optimally, with adequate information and services and without being condemned or judged if they do not want to or are unable to. However, breast milk substitute marketing negatively affects women's choices and can prevent both babies and mothers from enjoying the many health benefits of breastfeeding. Croatia should fully align with the International Code of Marketing of Breast-milk Substitutes, including the sanctioning of Code violators and subsequent relevant World Health Assembly resolutions.

95. Additional challenges in the area include the monitoring of breastfeeding practices, which is currently insufficient and not uniform throughout the country; the feeding of children whose mothers are HIV positive, on which guidelines are yet to be developed; and infant feeding in emergency situations, on which there is still a lack of policy measures to protect breastfeeding.

B. People on the move

96. Croatia is still perceived as a transit country, with some 70 per cent of asylum seekers absconding from the country to continue their onward movement. Between September 2015 and March 2016, a total of 658,068 refugees and migrants transited Croatia during the refugee emergency response. Subsequent to the closure of the "Western Balkans route" in March 2016, there was an increase in the number of asylum seekers in Croatia, including individuals transferred to Croatia under the Dublin II Regulation. By the end of September 2016, the Government had recorded 1,584 asylum seekers, which, compared with the annual statistics for 2015 (211), indicates a considerable increase. Reception capacity is 700 persons, with centres in Porin, Zagreb and Kutina, about 80 km from Zagreb.

97. Croatia is a signatory to the main international and regional instruments protecting the rights of refugees and stateless persons, notably, the Act on International and Temporary Protection 2015, adopted in July of that year to harmonize national asylum

legislation with the European Union acquis communautaire regulating protection of third country nationals.

98. Asylum seekers in Croatia are entitled to health care through the Mental Health Insurance Act and Law on Mandatory Health Insurance and Health Care for Foreigners in the Republic of Croatia. However, with the most recent amendments to the Act on International and Temporary Protection, health care in Croatia was restricted to emergency care and the most essential treatment of illnesses and serious mental conditions, thereby restricting effective access to health care. This has particularly affected children and pregnant women who are both asylum seekers and migrants. An additional barrier is language, as free interpreting services are not provided by the Government and most asylum seekers are unable to pay for such assistance.

99. As ascertained by the Special Rapporteur, many children arriving in Croatia have not been vaccinated against preventable diseases. Urgent efforts are needed to vaccinate all children without relevant health records who arrive or are born in Croatia and to provide all pregnant women with regular medical care, irrespective of their nationality or legal status. Likewise, medical check-ups upon arrival should be immediately reinstated.

100. The Special Rapporteur observed that, since September 2016, the provision of services had improved at the Porin Reception Centre, with the regular attendance of a general practitioner and the support of the non-governmental organization Médecins du Monde. However, he also noted the need for the national authorities to promptly undertake the work currently carried out by that organization in order to ensure continuity, ownership and compliance with international obligations. Similarly, the regular presence of a general practitioner in Kutina should be ensured, as at the time of the visit this was still lacking.

101. The Special Rapporteur was informed about the outstanding work done by humanitarian organizations vis-à-vis the refugee emergency response. These organizations should have access to all migrants in need irrespective of their legal status. Migrants should always be treated in a way that respects their dignity and upholds their fundamental rights. Notwithstanding the valuable work of humanitarian organizations, the State remains the main duty-bearer responsible for ensuring the protection and the full realization of the rights of people on the move.

C. Roma

102. Croatia has invested relevant efforts in improving the inclusion of Roma, including the National Roma Inclusion Strategy 2013-2020 and the related Action Plans. A significant aspect is the introduction of "health mediators" recruited from Roma communities to provide direct support in accessing health-care services. The Special Rapporteur noted the Government's awareness of the ongoing challenging situation faced by Roma in Croatia, who remain the most marginalized minority, and the will to address challenges.

103. Ongoing and upcoming measures specifically targeting the Roma population are welcomed, but there is a need to further strengthen the existing framework.

104. Available data indicate that one fifth of Roma children in Croatia may not have access to health care and that infant mortality rates for Roma children, in particular mortality associated with sudden infant death syndrome and respiratory diseases, are significantly above the national average.

105. Roma women face various constraints in access to health care, as a result of multiple discrimination and social exclusion based on ethnicity affiliation, gender and social status. Available data indicate that 21 per cent of Roma women have never had any health insurance, with the exception of pregnant women who access public support for expectant mothers.

106. The main barriers for Roma in accessing health care relate to challenges in obtaining identity documents. By 2016, about 2,800 Roma were still without permanent or temporary

residence[41] and at risk of statelessness. While Roma in Croatia are insured, a critical gap relates to the fact that they pay for their own insurance.

107. In his visit to a Roma settlement, the Special Rapporteur noted that environmental conditions may be a threat to their health and aggravated by climate and other factors, including the inadequate collection of waste by the relevant authorities. He also observed that their diet is nutritionally deficient and is particularly affecting children, with a direct impact on school dropout rates. Deficient diets also largely contribute to aggravation of chronic diseases in adulthood.

D. People who use drugs

108. In 2015, health-care facilities treated 7,533 persons for psychoactive substance dependence, of whom nearly 1 in 10 was under 20. Most of the patients treated were in the 30-39 age group and opiate dependence was the predominant type.[42]

109. While the Ministry of Health is the body primarily responsible for treatment for drug dependence, certain treatments, including programmes for young drug users, rehabilitation and resocialization of drug dependence come under the Ministry of Social Policy. While the Ministry of Justice is responsible for treatment for drug dependence in prisons and during probation, the Office for Combating Drug Abuse, county authorities and certain donors also participate in therapeutic communities.

110. The national strategy on combating drug abuse (2012-2017) includes a public health approach with the purpose of reducing both the demand for, and the supply of, drugs in society, protecting the health of individuals, families and communities. County committees for combating drug abuse composed of experts and members of local administrations were established in 2014 and 2015 to coordinate the implementation of the Strategy at the local level.

111. Accordingly, while some hospital-based inpatient treatment and therapeutic communities remain, drug treatment in Croatia is centred on the provision of outpatient care, through county services for the promotion of mental health and dependence prevention. Services include individual and group psychotherapy, prescription and continuation of opioid substitution therapy and other pharmacological treatments and testing and counselling on a wide range of issues, with a prevalence of medication-based treatments and harm-reduction programmes, including substitution therapies and syringe programmes.

112. In his visit to the Split Counselling Centre for the Prevention and Treatment of Addiction, the Special Rapporteur welcomed the interdisciplinary approach applied in the prevention and treatment of drug dependence and associated mental health conditions, with services provided on a voluntary basis. The approach paves the way for a positive outcome for therapeutic interventions.

113. In addition to these centres, outpatient drug treatment is provided by some associations, general practitioners and some outpatient units in general hospitals, with psychosocial treatment for enhancing interpersonal relationships and users' life situations that complement opioid substitution therapy and other treatments. Guidelines for the psychosocial treatment of drug users in the health-care, social and prison system were adopted in 2014 to standardize the delivery of such treatment.

[41] UNHCR data quoted in Amnesty International report on Croatia 2016-2017. Available from https://www.amnesty.org/en/countries/europe-and-central-asia/croatia/report-croatia/.

[42] Croatian Institute of Public Health, *Croatian Health Statistics Yearbook 2015*, p. 23.

VI. Conclusions and recommendations

114. **Croatia has made significant advances towards the progressive realization of the right to health. Despite a number of challenges, the State has striven to make its health-care system sustainable and accessible.**

115. **Measures have been taken to develop and strengthen primary and specialized health care, with the investment of innovative efforts in mental health reforms and interdisciplinary approaches to address drug use and dependence.**

116. **The right to health should be promoted and protected not only through access to health services, supplies and facilities, which should be available, affordable, appropriate and of good quality. The right to health is also realized through the enjoyment of the underlying and social determinants of health, and it requires the design and implementation of cross-sectoral policies and programmes that focus not only on life-saving interventions but also on broader socioeconomic, cultural and environmental factors.**

117. **Health policies and programmes in Croatia should be guided by a rights-based approach with a strong emphasis on the principles of equality and non-discrimination, transparency, participation and accountability. Issues related to the right to health are intersectoral and should be addressed by means of horizontal approaches that promote the effective use of primary care and incorporate the concerted efforts of all stakeholders.**

118. **The Special Rapporteur recommends that the State:**

(a) **Further advance the right to health with rights-based policies, in line with the 2030 Agenda for Sustainable Development, avoiding any retrogressive measures and paying particular attention to groups in the most vulnerable situations, including women, children, people on the move, minorities, persons with intellectual, cognitive and psychosocial disabilities and older persons;**

(b) **Continue to promote and strengthen primary health care, seeking an optimal balance between general practitioners and specialists, while providing specialist outpatient care, ensuring coordination between specialists and general practitioners and improving the capacities and competencies of general practitioners and their teams;**

(c) **Strengthen primary level capacity for early intervention services for children, with a family-centred and interdisciplinary approach and clear guidelines for cross-sectoral collaboration among the health, education and social services sectors;**

(d) **Fully align with the International Code of Marketing of Breast-milk Substitutes by further developing mechanisms to monitor breastfeeding practices and produce guidelines and protocols for children whose mothers are HIV positive and for infant feeding in emergency situations;**

(e) **Produce official reliable statistics on the remaining challenges for the health system, including long waiting lists; access to maternity hospitals, information on medically assisted reproduction; contraceptive prevalence; unmet needs for family planning, and the prevalence of conscience-based refusals to abortion in order to assist in the development of practical measures to address these issues;**

(f) **Give priority to women's and children's rights in the area of sexual and reproductive health rights, with appropriate access to safe, reliable and good quality contraception, comprehensive maternal health services, safe abortion and treatment for complications from unsafe abortion;**

(g) **Develop comprehensive sexuality education in schools, build the capacities of teachers in this area, and monitor programme performance;**

(h) **Ensure that informed consent is obtained by allocating adequate time to inform users about treatments, their effects and options on the basis of services that**

are sensitive to the rights of all users and through improved training of medical doctors and other health-care personnel in human rights and medical ethics;

(i) Invest resources, including European Union structural funds, ensuring a modern rights-compliant approach to mental health-care system throughout the country, with the aim of strengthening community-based outpatient services that can help stop excessive referrals to long-term care institutions;

(j) Cease directing funds/investments, either national or international, to reinforcing the inefficient system of segregated large psychiatric hospitals and residential institutions, and redirect them to the development of community-based services which focus on the needs and rights of the users and not on the needs of the existing service infrastructure;

(k) Replicate throughout the country the good practices of deinstitutionalization, with local plans in each county and the meaningful participation of relevant stakeholders;

(l) Immediately reinstate mandatory initial medical check-ups upon arrival in the country for people on the move, and build capacity to assume responsibility for the services provided by non-governmental organizations in reception centres, in close collaboration with the latter;

(m) Urgently develop measures to vaccinate all children without relevant health records that arrive or are born in Croatia and provide all pregnant women with regular medical care, irrespective of their nationality or legal status;

(n) In the context of the refugee emergency response, ensure access by humanitarian organizations to all migrants in need, irrespective of their legal status;

(o) Expand health-care insurance and services for Roma with outreach programmes for Roma children and mothers.

119. The Special Rapporteur recommends that all stakeholders in Croatia support policies based on universal human rights principles, including sexual and reproductive health rights, and reject patriarchal approaches and gender stereotypes detrimental to the enjoyment of all human rights, in particular the right to health of women and children.

United Nations A/HRC/35/22

General Assembly

Distr.: General
30 March 2017

Original: English

Human Rights Council
Thirty-fifth session
6-23 June 2017
Agenda item 3
Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Report of the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression

Note by the Secretariat

The Secretariat has the honour to transmit to the Human Rights Council the report of the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression, David Kaye, prepared pursuant to Council resolution 25/2. In his two previous reports to the Council, the Special Rapporteur focused on the freedom of opinion and expression in the digital age, detailing how encryption and anonymity tools provide the security necessary for the exercise of freedom of expression (A/HRC/29/32) and mapping the ways in which the information and communications technology sector implicates freedom of expression (A/HRC/32/38). In the present report, he addresses the roles played by private actors engaged in the provision of Internet and telecommunications access. He begins by examining State obligations to protect and promote freedom of expression online, then evaluates the digital access industry's roles, to conclude with a set of principles that could guide the private sector's steps to respect human rights.

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Report of the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression

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I. Introduction

1. States increasingly rely on the digital access industry to control, restrict or monitor expression online. When authorities seek to disconnect users from websites, social media, or the Internet entirely, they frequently require the assistance of Internet service providers (ISPs). They interfere with the Internet exchange points (IXPs) that facilitate traffic into or within a country. They access private communications and other personal data held by telecommunications providers. Today, many of these actors are privately owned or operated. Under protest, in silent acquiescence or as willing participants, they are often essential to State censorship and surveillance. What governments demand of private actors, and how those actors respond, can cripple the exchange of information; limit journalists' capacity to investigate securely; deter whistle-blowers and human rights defenders. Private actors may also restrict freedom of expression on their own initiative. They may assign priority to Internet content or applications in exchange for payment or other commercial benefits, altering how users engage with information online. Companies that offer filtering services may influence the scope of content accessible to their subscribers.

2. States and private actors both implicate the freedom of expression. State obligations to protect freedom of expression are clear, but what do private actors owe their users? How should they respect freedom of expression? What steps are they taking to assess and address the risks that their responses to government actions and policies might pose to freedom of expression and privacy? How much information should they share with their customers about State demands and requests? When they are directly involved or linked to abuse, what remedies should be available to individuals or the broader public whose interests are at risk?

3. The private actors that make digital access possible mediate and enable the exercise of freedom of expression. To be sure, States drive most censorship and surveillance. But just as States often, but not always, rely upon providers to take the actions that make censorship possible, we as users — beneficiaries of the remarkable advances of the digital age — deserve to understand how those actors interact with one another, how those interactions and their independent actions affect us and what responsibilities providers have to respect fundamental rights.

4. The present report is the result of over one year's worth of study and consultation that began with the mapping in 2016 of the information and communications technology (ICT) sector (see A/HRC/32/38).[1] In response to a call for submissions,[2] the Special Rapporteur received 25 submissions from States; 3 from companies; 22 from civil society, academics and others; and 1 confidential submission. In addition, the Special Rapporteur convened a brainstorming session hosted by ARTICLE 19, in London in July 2016, a meeting of experts at the Human Rights Institute, University of Connecticut, United States of America, in October 2016, a regional consultation with the Special Rapporteur for Freedom of Expression of the Inter-American Commission on Human Rights, in Guadalajara, Mexico, in December 2016, and a regional consultation in Beirut in February 2017.[3]

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[1] I want to thank Amos Toh, legal adviser to the mandate and Ford Foundation Fellow at University of California, Irvine, School of Law, for his expert research and analysis as well as coordination of substantial and essential research conducted by law students in University of California, Irvine, International Justice Clinic.

[2] See https://freedex.org/new-call-for-submissions-freedom-of-expression-and-the-telecommunications-and-internet-access-sector/.

[3] Submissions may be found on the website of the mandate. An overview of the consultations held and input received in the preparation of the present report may be found in a supplementary annex also available from the website of the mandate.

II. State obligation to protect and promote freedom of expression online

5. International human rights law establishes the right of everyone to hold opinions without interference and to seek, receive and impart information and ideas of all kinds, regardless of frontiers, and through any media of his or her choice (see Universal Declaration of Human Rights, art. 19, and International Covenant on Civil and Political Rights, art. 19). The Human Rights Council and General Assembly have reiterated that the freedom of expression and other rights apply online (see Council resolutions 26/13 and 32/13; General Assembly resolutions 68/167 and A/HRC/32/38). The Human Rights Committee, previous mandate holders and the Special Rapporteur have examined States' obligations under article 19 of the Covenant. In short, States may not interfere with, or in any way restrict, the holding of opinions (see art. 19 (1) of the Covenant, and A/HRC/29/32, para. 19). Article 19 (3) of the Covenant provides that States may limit freedom of expression only where provided by law and necessary for the respect of the rights or reputations of others, or for the protection of national security or of public order (ordre public), or of public health or morals (see Human Rights Committee general comment No. 34 (2011); A/71/373; and A/HRC/29/32).

6. States also have obligations to take steps to protect individuals from undue interference with human rights when committed by private actors (see art. 2 (2) of the Covenant; and Human Rights Committee general comment No. 31 (2004)). Human rights law protects individuals against violations by the State as well as abuses committed by private persons or entities (see general comment No. 31, para. 8).[4] The Guiding Principles on Business and Human Rights: Implementing the United Nations "Protect, Respect and Remedy" Framework, endorsed by the Human Rights Council in 2011, explains that States are required to take appropriate steps to prevent, investigate, punish and redress private actors' abuse (see A/HRC/17/31, annex, principle 1). Such steps include the adoption and implementation of legislative, judicial, administrative, educative and other appropriate measures that require or enable business respect for freedom of expression, and, where private sector abuses occur, access to an effective remedy (see general comment No. 31, para. 7; and A/HRC/17/31, annex, principles 3 and 25).

7. The government actions described below often fail to meet the standards of human rights law. Moreover, a lack of transparency pervades government interference with the digital access industry. Failures of transparency include vague laws providing excessive discretion to authorities, legal restrictions on third party disclosures concerning government access to user data and specific gag orders. The lack of transparency undermines the rule of law as well as public understanding across this sector.[5]

A. Internet and telecommunications shutdowns

8. Internet and telecommunications shutdowns involve measures to intentionally prevent or disrupt access to or dissemination of information online in violation of human rights law (see A/HRC/32/13, para. 10).[6] Governments typically conduct or order shutdowns, often with the assistance of private actors that operate networks or facilitate network traffic. Large-scale attacks on network infrastructure committed by private parties, such as distributed denial-of-service (DDoS) attacks, may also have shutdown effects. While shutdowns are frequently associated with total network outages, they may also arise when access to mobile communications, websites or social media and messaging

[4] See also African Commission on Human and Peoples' Rights, general comment No. 3 (2015) on the right to life, para. 38; Inter-American Court of Human Rights, *Velásquez Rodríguez Case*, judgment of 29 July 1988, para. 172; and European Court of Human Rights, *Özel and others v. Turkey*, judgment of 17 November 2015, para. 170.

[5] Freedom Online Coalition, Report of Working Group 3: Privacy and Transparency Online, November 2015.

[6] Access Now recorded 15 shutdowns in 2015 and 56 shutdowns in 2016. The first recorded shutdown reportedly occurred in Nepal in February 2005.

applications is blocked, throttled or rendered "effectively unusable".[7] Shutdowns may affect towns or regions within a country, an entire country or even multiple countries and may last for periods ranging from hours to months.

9. Shutdowns ordered covertly or without an obvious legal basis violate the requirement of article 19 (3) of the Covenant that restrictions be "provided by law". In Chad, the failure of authorities to provide a meaningful public explanation for a series of Internet and social media shutdowns between February and October 2016 created the presumption that they were unlawful.[8] In Gabon, total network outages were allegedly recorded every evening for almost two weeks during the 2016 election period, contrary to government assurances that such services would not be disrupted.[9]

10. Shutdowns ordered pursuant to vaguely formulated laws and regulations also fail to satisfy the legality requirement. In Tajikistan, the amended Law on the State of Emergency authorizes the Government to block mobile services and Internet access without a court order following the declaration of a state of emergency.[10] The law fails to define when and for what purposes a state of emergency may be declared. Such ambiguity enables authorities' unfettered discretion to implement shutdowns. In some countries, authorities rely on antiquated laws to justify shutdowns.[11] Laws and regulations adopted and implemented in secret also violate the legality requirement. In the United States of America, the National Coordinating Center for Telecommunications has largely redacted public release of standard operating procedure 303, an executive regulation that establishes "detailed procedures" on the "disruption of cellular service."[12] While these procedures have not been publicly invoked, the potential for authorities to evade legal scrutiny and public accountability runs contrary to article 19 of the Covenant.

11. Restrictions on expression must be necessary to achieve aims specified by article 19 (3) of the Covenant and may never be invoked to justify the suppression of advocacy for democratic rights (see Human Rights Committee general comment No. 34, para. 23; and A/71/373, para. 20). However, governments frequently impose shutdowns during demonstrations, elections and other events of extraordinary public interest, with little or no explanation.[13] In Bahrain, disruptions to mobile and Internet access in Duraz allegedly coincided with visits outside the home of a prominent religious leader whose citizenship the Government had revoked.[14] Internet users in the Bolivarian Republic of Venezuela were reportedly denied Internet access during widespread protests against the Government in 2014.[15] Network disruptions have been recorded during or around elections or protests in

[7] Access Now submission, part I, p. 1.

[8] Internet Sans Frontières submission, p. 2; A/HRC/32/38/Add.2.

[9] Ibid., GAB 1/2016.

[10] OHCHR, "Preliminary observations by the United Nations Special Rapporteur on the right to freedom of opinion and expression, Mr. David Kaye, at the end of his visit to Tajikistan, press release (9 March 2017).

[11] India, Code of Criminal Procedure, sect. 144; also Apar Gupta and Raman Jit Singh Chima, "The cost of internet shutdowns", *The Indian Express* (28 October 2016).

[12] United States of America, NCS, Standard Operating Procedure (SOP) 303.

[13] Access Now submission, part I, pp. 4-5.

[14] Bahrain Center for Human Rights, *Digital Rights Unveiled in Bahrain* (2016), pp. 13-14.

[15] Danny O'Brien, "Venezuela's Internet crackdown escalates into regional blackout", Electronic Frontier Foundation (20 February 2014).

Cameroon,[16] the Gambia,[17] India,[18] Myanmar,[19] the Islamic Republic of Iran,[20] Uganda[21] and Montenegro.[22]

12. The failure to explain or acknowledge shutdowns creates the perception that they are designed to suppress reporting, criticism or dissent. Reports of repression and State-sanctioned violence in the wake of network disruptions have led to allegations that some States exploit the darkness to commit and cover up abuses. In Sudan, for example, Internet access was shut down for several hours during a deadly crackdown on demonstrators protesting fuel price hikes in September 2013.[23]

13. Observers have also noted the growing use of shutdowns to prevent cheating by students during national exams. Uzbekistan may have been the first to invoke this justification during university entrance exams in 2014.[24] In 2016, authorities allegedly ordered shutdowns during exams in India, Algeria, Ethiopia and Iraq.[25]

14. Network shutdowns invariably fail to meet the standard of necessity. Necessity requires a showing that shutdowns would achieve their stated purpose, which in fact they often jeopardize. Some governments argue that it is important to ban the spread of news about terrorist attacks, even accurate reporting, in order to prevent panic and copycat actions.[26] Yet it has been found that maintaining network connectivity may mitigate public safety concerns and help restore public order. During public disturbances in London in 2011, for example, authorities used social media networks to identify perpetrators, disseminate accurate information and conduct clean-up operations. In Kashmir, police have reported on the positive role of mobile phones in locating people trapped during terrorist attacks.[27]

15. Duration and geographical scope may vary, but shutdowns are generally disproportionate. Affected users are cut off from emergency services and health information, mobile banking and e-commerce, transportation, school classes, voting and election monitoring, reporting on major crises and events, and human rights investigations.[28] Given the number of essential activities and services they affect, shutdowns restrict expression and interfere with other fundamental rights.

16. Shutdowns also affect areas beyond those of specific concern.[29] In the lead up to the 2015 National Day Parade in Pakistan, mobile communications networks were allegedly cut off at the parade site as well as in surrounding areas that were not expected to experience any potential security threat.[30] During the Pope's visit to the Philippines in 2015, the shutdown of mobile networks for safety reasons affected areas well beyond the travel

[16] OHCHR, "UN expert urges Cameroon to restore Internet services cut off in rights violation", press release (10 February 2017).
[17] Deji Olukotun, "Gambia shuts down Internet on eve of elections", Access Now (30 November 2016).
[18] Software Freedom Law Center, "Internet shutdowns in India, 2013-2016".
[19] Freedom House, "Freedom on the Net: Myanmar" (2011).
[20] Center for Democracy and Technology, "Iran's Internet throttling: unacceptable now, unacceptable then" (3 July 2013).
[21] Article 19, "Uganda: Blanket ban on social media on election day is disproportionate" press release (18 February 2016).
[22] Global Voices, "WhatsApp and Viber blocked on election day in Montenegro" (17 October 2016).
[23] Human Rights Watch, "Sudan: Dozens killed during protests" (27 September 2013).
[24] Access Now submission, part I; also Freedom House, "Freedom on the Net: Uzbekistan" (2016).
[25] Access Now submission, part I.
[26] See for example, OHCHR, "Preliminary conclusions and observations by the UN Special Rapporteur on the right to freedom of opinion and expression to his visit to Turkey, 14-18 November 2016", press release (18 November 2016).
[27] Institute for Human Rights and Business (IHRB), "Security v. Access: The impact of mobile network shutdowns", case study: Telenor Pakistan (September 2015), pp. 31-32.
[28] Access Now submission, part I, pp. 11-14; also Global Network Initiative submission.
[29] IHRB, "Security v. Access: The impact of mobile network shutdowns", case study: Telenor Pakistan (September 2015), p. 20.
[30] Ibid., pp. 27-28.

route.[11] When specific services or platforms are disrupted, governments typically target those that are the most efficient, secure or widely used.[12]

B. Government access to user data

17. Government surveillance today relies on access to communications and associated data belonging to users of privately owned networks. While such access frequently requires the assistance of private actors, it may also be obtained without their knowledge or involvement. As with other forms of surveillance, government access to user data may interfere with privacy in a manner that can both directly and indirectly limit the free development and exchange of ideas (see A/HRC/23/40, para. 24). Undue access to personal data implicitly warns users to think twice and possibly avoid controversial viewpoints, the exchange of sensitive information and other exercises of freedom of expression that may be under government scrutiny (see A/HRC/27/37, para. 20).

Requests for user data

18. Vague laws and regulations violate the legality requirement (see A/HRC/23/40, para. 50). The Communications and Multimedia Act of Malaysia, for example, permits authorities to order the disclosure of "any communication or class of communications" on "the occurrence of any public emergency or in the interest of public safety". The Act does not define the conditions that trigger a public emergency and certification by the King is deemed "conclusive proof on the point".[13] In Qatar, law enforcement enjoys a broad right to seek access to providers' customer communications in cases of national security or emergency.[14] These provisions empower authorities to request user data based on a mere assertion of national security. Users are thus unable to predict with reasonable certainty the circumstances under which their communications and associated data may be disclosed to authorities.

19. Providers should only be compelled to release user data when ordered by judicial authorities certifying necessity and proportionality to achieve a legitimate objective. The Criminal Code of Canada requires law enforcement to submit requests for the disclosure of telephone records in criminal investigations to a judge for approval.[15] In Portugal, the authorities must obtain a judicial order to compel the disclosure of communications data.[16] However, national law often exempts user data requests from judicial authorization. In Bangladesh, the authorities require only executive branch approval to access communications data belonging to telecommunications subscribers on the grounds of national security and public order.[17]

20. Laws that require private actors to create large databases of user data accessible to the government raise necessity and proportionality concerns. In Kazakhstan, telephone numbers, e-mail and Internet Protocol (IP) addresses and billing information must be stored by the provider for two years.[18] The Russian Federation requires private actors to store the content of all their customers' calls and text messages for six months, and related communications metadata for three years.[19] Both countries also require such data to be stored locally.[20] In countries where mobile phones are a dominant means of communication, mandatory SIM card registration laws effectively require the majority of the population to divulge personally identifiable information (see A/HRC/29/32, para. 51).

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[11] Deniz Duru Aydin, "Five excuses governments abuse to justify Internet shutdowns" Access Now (6 October 2016).

[12] Article 19 submission, p. 2.

[13] Malaysia, Communications and Multimedia Act (1998), sect. 266.

[14] Qatar, Decree Law No. (34) of 2006.

[15] See submission from Canada, p. 6.

[16] Portugal, Criminal Proceedings Code, arts. 187-190.

[17] Bangladesh, Telecommunication Regulatory Act (2001), sect. 97 (Ka).

[18] Kazakhstan, Government resolution No. 1593 (23 December 2011).

[19] OHCHR, letter to the Government of the Russian Federation, 28 July 2016 (OL RUS 7/2016).

[20] Article 19 submission, p. 5.

The mandatory retention of large amounts of user data runs contrary to established due process standards, such as the need for individualized suspicion of wrongdoing.

Undermining encryption

21. Since the Special Rapporteur's report on encryption and anonymity (A/HRC/29/32), unnecessary and disproportionate measures to undermine encryption have increased globally and threaten to undermine both the freedom of expression and digital security of users. In the United Kingdom of Great Britain and Northern Ireland, for example, the 2016 Investigatory Powers Act permits the Secretary of State to issue "technical capability notices" that require providers to remove "electronic protection" from communications — a measure that could compel backdoors or otherwise limit or weaken encryption.[41] States have not provided sufficient evidence that such vulnerabilities are the least intrusive means of protecting national security and public order, particularly given the breadth and depth of other investigative tools at their disposal (Ibid., para. 39).

Direct access

22. Direct access to Internet and telecommunications networks enables authorities to intercept and monitor communications with limited legal scrutiny or accountability. Technological advances have enhanced the ability of law enforcement and intelligence agencies to obtain a direct connection to networks without the involvement or knowledge of the network operator.[42] During the 2014 general election in the former Yugoslav Republic of Macedonia, intelligence authorities allegedly obtained direct access to the country's major telecommunications networks to intercept the communications of over 20,000 people, including politicians, activists, government officials and journalists. Many targets were also sent a transcript of their phone calls.[43] In India, it appears that authorities are developing a Central Monitoring System programme that would enable "electronic provisioning of target numbers by government agency without any manual intervention from telecommunications service providers on a secure network."[44] These activities do not appear to be provided by law, lacking both judicial authorization and external oversight. Furthermore, the risks they pose to the security and integrity of network infrastructure raise proportionality concerns.

C. Net neutrality

23. Network neutrality — the principle that all Internet data should be treated equally without undue interference — promotes the widest possible access to information.[45] In the digital age, the freedom to choose among information sources is meaningful only when Internet content and applications of all kinds are transmitted without undue discrimination or interference by non-State actors, including providers. The State's positive duty to promote freedom of expression argues strongly for network neutrality in order to promote the widest possible non-discriminatory access to information.

Paid prioritization

24. Under paid prioritization schemes, providers give preferential treatment to certain types of Internet traffic over others for payment or other commercial benefits. These schemes effectively create Internet fast lanes for content providers that can afford to pay extra and slow lanes for all others.[46] This hierarchy of data undermines user choice. Users

[41] United Kingdom of Great Britain and Northern Ireland, Investigatory Powers Act (2016), art. 253; *also* OHCHR, letter to the Government of the United Kingdom, 22 December 2015 (AL GBR 4/2015).

[42] Privacy International submission, and Telecommunications Industry Dialogue submission, p. 3.

[43] Privacy International, "Macedonia: Society On Tap" (23 March 2016).

[44] Access Now submission, part II, p. 4.

[45] Luca Belli submission, and Article 19 submission, pp. 7-8.

[46] Dawn C. Nunziato and Arturo J. Carrillo, "The price of paid prioritization: The international and domestic consequences of the failure to protect Net neutrality in the United States", Georgetown

experience higher costs or lower quality of service when they attempt to access Internet content and applications in the slow lanes. At the same time, they may be compelled to engage with content that has been prioritized without their knowledge or input.

25. Several States prohibit paid prioritization. For example, the Netherlands, an early adopter of net neutrality, forbids providers from making "the price of the rates for Internet access services dependent on the services and applications which are offered or used via these services".[47] The United States Federal Communications Commission 2015 Open Internet Order bans the "management of a broadband provider's network to directly or indirectly favour some traffic over other traffic ... in exchange for consideration (monetary or otherwise) from a third party, or to benefit an affiliated entity".[48]

Zero rating

26. Zero rating is the practice of not charging for the use of Internet data associated with a particular application or service; other services or applications, meanwhile, are subject to metered costs. Zero rating arrangements vary from data plans that exempt certain Internet services from a subscriber's usage count to the provision of unmetered access to certain services without the purchase of a plan.[49] Variations notwithstanding, zero rating arrangements privilege access to content and may increase the cost of metered data. For users who struggle to afford metered data, they might end up relying exclusively on zero-rated services, resulting in limited access to information for communities that may already be marginalized in their access to information and public participation.

27. Zero rating arrangements may provide users with limited Internet access [...] areas that would otherwise completely lack access.[50] However, broader Internet access may still remain out of reach for users, trapping them in permanently walled online gardens.[51] The assumption that limited access will eventually ripen into full connectivity requires further study. It may be dependent upon factors such as user behaviour, market conditions, the human rights landscape and the regulatory environment.[52]

28. These competing considerations have led to variations in regulatory approaches. In India, public concern over Facebook's Free Basics culminated in a ban on any arrangement that "has the effect of discriminatory tariffs for data services being offered or charged to the consumer on the basis of content".[53] Restrictions on zero rating are in effect in Chile, Norway, the Netherlands, Finland, Iceland, Estonia, Latvia, Lithuania, Malta and Japan.[54] In contrast, the United States, followed later by the Body of European Regulators for Electronic Communications (BEREC), adopted guidelines involving a case-by-case approach.[55] States that adopt a case-by-case approach should carefully scrutinize and, if necessary, reject arrangements that, among other things, zero-rate affiliated content, condition zero rating on payment or favour access to certain applications within a class of

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Journal of International Affairs: International Engagement on Cyber V: Securing Critical Infrastructure (2 October 2015), p. 103.

[47] Netherlands, Telecommunications Act, art. 7.4a (3).

[48] United States of America, Federal Communications Commission, Protecting and Promoting the Open Internet, FCC 15-24 (12 March 2015), para. 18. This Order, possibly under threat at the time of writing the present report, remains a useful template for net neutrality regulation.

[49] Erik Stallman and R. Stanley Adams, IV, "Zero Rating: A framework for assessing benefits and harms", Center for Democracy and Technology (January 2016).

[50] Ibid., pp. 4 and 11.

[51] Barbara van Schewick, "Network neutrality and zero-rating", submission to the United States Federal Communications Commission (19 February 2014), p. 7.

[52] Erik Stallman and R. Stanley Adams, IV, "Zero Rating: A framework for assessing benefits and harms" (January 2016), p. 15.

[53] India, Telecom Regulatory Authority, "TRAI releases the Prohibition of Discriminatory Tariffs for Data Services Regulations, 2016", press release (8 February 2016).

[54] Emily Hong, "A zero sum game? What you should know about zero-rating", *New America Weekly*, Edition 109 (4 February 2016).

[55] United States, Federal Communications Commission, Protecting and Promoting the Open Internet, FCC 15-24 (12 March 2015), para. 21; and BEREC, Guidelines on the Implementation by National Regulators of European Net Neutrality Rules (August 2016) (BoR (16) 127).

similar applications (for example, zero rating certain music streaming services rather than all music streaming). Additionally, States should require meaningful corporate disclosures about network traffic management practices. For example, Chile requires ISPs to disclose Internet access speeds, price or speed differentials between national and international connections, and related service guarantees.[56]

III. Digital access providers and freedom of expression

29. While the duty of States to respect and protect freedom of expression is well-established, the private actors that establish, operate and maintain digital access also play a critical role.

A. Telecommunications and Internet service providers

30. Telecommunications providers (Telcos) and ISPs (collectively referred to in the present report as "providers") offer a diverse range of services. While they principally operate and sell access to the series of networks that comprise the Internet, they also enable users to communicate and share information through mobile services and traditional landlines (see A/HRC/32/38, para. 16). While providers remain State-owned in many regions, a growing number are now privately established and managed. The industry is also increasingly multinational: some of the world's biggest providers operate networks in multiple countries and regions, often through partnerships with domestic companies or their own subsidiaries.

31. As gatekeepers of vast information networks, providers face significant government pressure to comply with censorship and surveillance activities. To operate a network in a country, they are required to invest substantial physical and business infrastructure, including network equipment and personnel. They are typically subject to local law and other licensing requirements set out in agreements with the State. In addition to legal pressure, providers have also faced extralegal intimidation, such as threats to the safety of their employees and infrastructure in the event of non-compliance.[57]

32. While several providers attempt to resist censorship and surveillance requests, many assist in government efforts without meaningful challenge. In the United States, one of the country's largest providers is alleged to have created a "super search engine" to facilitate law enforcement access to customer phone calls, even though not legally required to do so.[58] In the United Kingdom, a complaint filed with the Organization for Economic Cooperation and Development alleged that major providers granted the country's intelligence agency access to their networks and customer data well beyond what was required by the law at the time.[59]

33. A growing number of providers are establishing arrangements with media and other content-producing companies that threaten net neutrality and are lobbying intensely for concessions on net neutrality standards. For example, as European regulators were developing net neutrality guidelines, 17 major providers in the region issued the "5G Manifesto", warning that "excessively prescriptive" guidelines would delay their investment in 5G, the next generation of mobile Internet connection.[60]

[56] Chile, Ley No. 20.453, art. 24 H (D).

[57] Telecommunications Industry Dialogue submission, p. 10.

[58] Dave Maass and Aaron Mackey, "Law enforcement's secret 'super search engine' amasses trillions of phone records for decades", Electronic Frontier Foundation (29 November 2016).

[59] Privacy International, "OECD complaint against BT, Verizon Enterprise, Vodafone Cable, Viatel, Level 3, and Interoute".

[60] Article 19 submission, p. 9.

B. Internet exchange points

34. IXPs enable the exchange of Internet traffic between and among networks managed by different providers within a country or region.[61] This form of interconnection prevents local or regional Internet traffic from taking long and circuitous international routes, thus enhancing the speed and efficiency of Internet connectivity. IXPs may be established by Internet infrastructure companies as part of a broader suite of services sold to providers or operated as non-profit or volunteer organizations.[62]

35. IXPs handle an enormous volume of Internet traffic that may be filtered or intercepted at government request. The growing number of censorship and surveillance incidents involving IXPs indicates that they are major access choke points, even if their precise role is unclear. For example, in 2013, the manner in which access to YouTube was blocked in Pakistan indicated that the platform was filtered by IXPs, rather than ISPs, through a method known as "packet injection".[63] According to a leaked internal memo of a multinational ISP operating in Ecuador, users were unable to access Google and YouTube in March 2014 because the private Association of Internet Providers of Ecuador — which runs two of the major IXPs in the country — was "blocking access to certain Internet websites by request of the national Government".[64] The revelations of mass surveillance conducted by the United States National Security Agency have raised concern among technologists that the agency is intercepting a significant proportion of domestic and foreign Internet traffic by targeting United States IXPs.[65] In September 2016, the world's largest Internet exchange point, which is based in Germany, challenged legal orders issued by the country's intelligence agency to monitor international communications transiting through its hub.[66]

C. Content delivery networks

36. A content delivery network (CDN) is a network of servers strategically distributed around the world to enable the efficient delivery of web pages and other Internet content. Large content producers rely on content delivery networks to reach as many users as quickly as possible.[67] A content delivery network stores copies of content hosted on these platforms and redirects a user's request for such content from the platform's servers to the servers within its network that are located closest to the user.[68] This process enhances the speed of content delivery, particularly to users located far away from the platform's servers. Content delivery networks are regarded as an effective safeguard against website blocking: censorship measures targeting servers that host a particular website or platform do not affect the content delivery network's delivery of copies of the same content to users.[69] Content delivery networks have also become a critical bulwark against network disruptions. The demands of rapid access have incentivized them to invest significant resources in infrastructure and services that can withstand distributed denial-of-service and other malicious attacks.[70]

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[61] See www.bgp4.as/internet-exchanges/.

[62] Jason Gerson and Patrick Ryan, "A primer on Internet exchange points for policymakers and non-engineers" *Social Science Research Network* (12 August 2012), p. 10.

[63] Zubair Nabi, "The anatomy of web censorship in Pakistan" (2013), p. 4.

[64] Katitza Rodriguez, "Leaked documents confirm Ecuador's Internet censorship machine", Electronic Frontier Foundation (14 April 2016).

[65] Andrew Clement and Jonathan Obar, "Canadian Internet 'boomerang' traffic and mass NSA surveillance: Responding to privacy and network sovereignty challenges", in *Law, Privacy and Surveillance in Canada in the Post-Snowden Era*, Michael Geist, ed. (University of Ottawa Press, 2015).

[66] De Cix, "Information on the lawsuit against the Federal Republic of Germany" (16 September 2016).

[67] Geoff Huston, "The death of transit?", Asia Pacific Network Information Centre (27 October 2016).

[68] Vangie Beal, "CDN – Content Delivery Network", *Webopedia*.

[69] John Holowczak and Amir Houmansadr, "CacheBrowser: bypassing Chinese censorship without proxies using cached content" (2015).

[70] Geoff Huston, "The death of transit?", Asia Pacific Network Information Centre (27 October 2016).

37. The censorship resilience of content delivery networks has also made them targets of disproportionate restrictions on freedom of expression. In Egypt, the blocking of *The New Arab* website in August 2016 also disrupted access to content on other sites that, although unaffiliated, shared the same content delivery network, which led researchers to believe authorities had targeted that particular network.[71] In China, a national filter has reportedly blocked EdgeCast content delivery network, which handles content for a number of large websites in the country.[72]

38. Since content delivery networks process large volumes of user requests for Internet content from multiple websites and platforms, they are also vulnerable to government surveillance. In 2016, for example, Amazon Web Services, which houses one of the world's biggest content delivery networks,[73] reported that government requests to access data more than doubled from the previous year.[74] Researchers also believe that mass surveillance activities strategically target content delivery networks to maximize information collection, but specifically how this is conducted and the extent of content delivery network involvement, if any, is unclear.[75]

D. Network equipment vendors

39. Vendors supply the hardware and software that form the basis of Internet and telecommunications networks. Network equipment typically includes routers, switches and access points, which enable multiple devices and networks to connect with each other (see A/HRC/32/38, para. 18). Vendors have also diversified their business to provide Voice over Internet Protocol (VoIP) equipment, which enables wireless calls and Internet of Things (IoT) technology, which enables networking among smart devices.[76] Vendors are rarely consumer-facing: their main customers are network operators, such as governments, ISPs, or content delivery networks. As a result, they are required to configure networks to the technical standards specified by these operators, including standards dictated by local law (such as law enforcement and national security requirements). However, vendors may also design or modify equipment and technology to ensure consistency with private or government specifications.

40. Given their business model, vendors are required to navigate the human rights challenges that their customers face or create. In the area of surveillance, vendors are often bound by "lawful interception" measures, which require the configuration of networks to enable government access to user data.[77] Additionally, vendors may be contracted to establish "administration and mediation systems" that facilitate the sharing of intercepted data between the network operator and the government authority as well as the government systems that process the intercepted data.[78] In arrangements where vendors also manage the networks that they have built, they may also be responsible for handling government requests for user data on the operator's behalf.[79]

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[71] Leonid Evdokimov and Vasilis Ververis, "Egypt: Media censorship, Tor interference, HTTPS throttling, and ads injections?", Open Observatory of Network Interference (27 October 2016).

[72] Joss Wright, "A quick investigation of EdgeCast CDN blocking in China", blog, Oxford Internet Institute (18 November 2014).

[73] At the time of writing the present report, Amazon Cloudfront served the largest number of website domains in the world.

[74] Amazon Information Request Report (June 2016).

[75] See, for example, Harrison Weber, "How the NSA & FBI made Facebook the perfect mass surveillance tool", *Venture Beat* (15 May 2014).

[76] Michael E. Raynor and Phil Wilson, "Beyond the dumb pipe: The IoT and the new role for network service providers", Deloitte University Press (2 September 2015).

[77] See, for example, Council of the European Union resolution of 17 January 1995 on the lawful interception of telecommunications, Official Journal C 329; and Privacy International submission, pp. 2-3.

[78] IHRB, "Human rights challenges of telecommunications vendors: addressing the possible misuse of telecommunications systems: case study: Ericsson" (November 2014), p. 16.

[79] Ibid., p. 17.

41. The design of network equipment and technology with multiple uses raises freedom of expression and privacy concerns. Deep packet inspection devices, for example, are used for innocuous technical purposes such as the management of network congestion, but have also been employed to filter Internet content, intercept communications and throttle data flows. Mobile networks are configured to monitor the real-time location of cell phones to ensure that cellular services may be accessed from any location, but such monitoring may also be used to target users.[80]

42. Some evidence suggests that vendors may provide support for government censorship and surveillance. In a case pending before United States courts, Cisco has been accused of designing, implementing and helping to maintain a Chinese surveillance and internal security network known as the Golden Shield.[81] (Cisco denies those allegations.)[82] In Ethiopia, human rights groups found that ZTE Corporation had designed and installed a customer management database for Ethio Telecom that enabled intrusive surveillance.[83]

E. Other private actors

43. The findings and recommendations in the present report apply to any entity that engages in the provision of digital access as described above. A growing number of Internet companies are adding critical digital access and infrastructure services to their portfolio. For example, Alibaba and Tencent, two of the biggest Chinese Internet companies, now also offer content delivery network services.[84] Google has been experimenting with methods to provide wireless access that bypass traditional providers; in 2010, it launched a high-speed Internet connection service to homes and businesses in select cities in the United States.[85] It is also working with Facebook and Microsoft to build undersea cable networks that would enable them to connect users without relying on third-party equipment or systems.[86]

44. Standards developing organizations (SDOs), although not strictly "industry actors", establish technical protocols and standards that enable inter-operability in the telecommunications and Internet infrastructure. Standards development that neglects human rights considerations may adversely impact freedom of expression. For example, the failure to mandate Transport Layer Security (TLS) as a feature of the Hypertext Transfer Protocol (HTTP) left web traffic vulnerable to censorship and surveillance. The technical community's efforts to incorporate human rights due diligence into standards development is therefore a step in the right direction.[87]

IV. Human rights responsibilities of digital access providers

45. The Guiding Principles on Business and Human Rights recognize the responsibility of business enterprises to respect human rights, independent of State obligations or the implementation of those obligations (see A/HRC/17/31, annex; and A/HRC/32/38, paras. 9-10). They provide a minimum baseline for corporate human rights accountability, urging companies to adopt public statements of commitment to respect human rights endorsed by

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[80] Ibid., p. 13.

[81] United States District Court for the Northern District of California, San Jose Division, *Doe et al. v. Cisco Systems, Inc. et al.*, Case No. 5:11-cv-02449-EJD-PSGx (18 September 2013).

[82] John Earnhardt, "Cisco Q&A on China and censorship" Cisco blogs (2 March 2006).

[83] Human Rights Watch, "They know everything we do: telecom and Internet surveillance in Ethiopia" (25 March 2014).

[84] Tencent Cloud CDN and Alibaba Cloud CDN.

[85] Klint Finley, "Google eyes blazing-fast wireless as a way into your home", *Wired* (12 August 2016).

[86] Joon Ian Wong, "Google and Facebook are doubling down on Internet infrastructure with a new Pacific cable", *Quartz* (17 October 2016).

[87] Internet Research Task Force, "Research into human rights protocol considerations" (25 February 2017). Available at https://datatracker.ietf.org/doc/draft-irtf-hrpc-research/?include_text=1. The supplementary annex analyzes the roles and responsibilities of standards developing organizations in more detail.

senior or executive-level management; conduct due diligence processes that meaningfully "identify, prevent, mitigate and account for" actual and potential human rights impacts throughout the company's operations; and provide for or cooperate in the remediation of adverse human rights impacts (see A/HRC/17/31, annex, principles 16-24).

A. Context considerations

46. The Guiding Principles emphasize the need for companies to take into account the particularities of their operating context when executing their human rights responsibilities (Ibid.). In the digital access industry, several contexts must be considered.

Access providers supply a public good

47. The digital access industry is in the business of digital expression; its commercial viability depends on users who seek, receive and impart information and ideas on the networks it builds and operates. Since privately owned networks are indispensable to the contemporary exercise of freedom of expression, their operators also assume critical social and public functions. The industry's decisions, whether in response to government demands or rooted in commercial interests, can directly impact freedom of expression and related human rights in both beneficial and detrimental ways.

Restrictions on Internet access affect freedom of expression globally

48. The industry's human rights impacts are frequently global, affecting users even in markets beyond those served by the company concerned. For example, surveillance of a single Internet exchange point in the United States may capture large streams of communications among Americans and foreigners, and even those entirely among foreigners. Similarly, security vulnerabilities in network design affect all users who rely on the compromised network for digital access, including users located far away from the network. Accordingly, companies should identify and address the broader implications of their activities for freedom of expression generally, in addition to their impacts on customers or rights holders in the markets they operate. To be sure, the manner in which they account for their impacts may vary according to their size, resources, ownership, structure and operating context (Ibid., principle 14). For example, all providers should vet user data requests for compliance with a minimum set of formalities, regardless of the origin of the request or the user affected. But while a multinational provider may have dedicated teams vetting requests, a small or medium-size provider may task its legal or public policy teams to perform the same function.

The industry is vulnerable to State pressure against freedom of expression…

49. The Guiding Principles seek to address the gaps in corporate accountability left because of a lack of national legislation or implementation.[88] However, zealous enforcement of domestic law also poses human rights challenges in the digital access industry. For example, States may hold providers liable for, or otherwise pressure them to restrict, Internet content posted by users on their networks, under laws as varied as hate speech, defamation, cybercrime and lese-majesty. Yet such intermediary liability creates a strong incentive to censor: providers may find it safest not to challenge such regulation but to over-regulate content such that legitimate and lawful expression also ends up restricted. The pressure to assist in State censorship and surveillance also escalates when authorities harass, threaten or arrest employees, or attempt to tamper with the company's networks or equipment.[89]

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[88] Yael Ronen, "Big Brother's little helpers: the right to privacy and the responsibility of Internet service providers", *Utrecht Journal of International and European Law*, vol. 31, No. 80 (February 2015), p. 76.

[89] In 2014, a network shutdown request that the multinational telecommunications provider, Orange, received from the authorities in the Central African Republic was reportedly "accompanied by the

...but also uniquely situated to ensure respect for users' rights

50. The industry's dual role as an enabler of digital access and a natural point for State-imposed restriction heightens its importance as a bulwark against government and private overreach. For example, providers are usually best placed to push back on a shutdown or user data request. Content delivery networks are strategically positioned on the Internet infrastructure to counter malicious attacks that disrupt access. Vendors are uniquely qualified to assess whether their products will be or are being used to facilitate human rights abuses, particularly when they conduct sales due diligence or perform ongoing services.

B. Responsibility to respect users' freedom of expression

51. To operationalize its human rights commitments, the digital access industry should allocate appropriate resources to at least the practices described below. Although these principles are evaluated in the context of digital access, they also bear relevance to other sectors of the digital economy, such as social media, commerce, surveillance and search.

1. Due diligence

52. Due diligence processes enable a digital access provider to identify, prevent and mitigate the human rights impacts of its activities (see A/HRC/17/31, annex, principle 19). While one-size-fits-all due diligence approaches are neither possible nor advisable, human rights impact assessments provide a means of assessing and addressing risks to freedom of expression and privacy.[90] Due diligence involves at least the following.

Policies governing the conduct of due diligence

53. Companies should develop clear and specific criteria for identifying activities that implicate freedom of expression and trigger due diligence processes.[91] The company's past and ongoing human rights effects, as well as industry practice, provide useful indicators. In the digital access industry, such activities might include mergers and acquisitions; market entry or exit; government or non-government requests for content restriction or user data; the development of or changes to content restriction and privacy policies; product changes regarding content moderation or encrypted communications; arrangements that facilitate prioritized access to Internet content and applications; the design, sale and purchase of network interception and filtering equipment and technologies as well as associated training and consultation services.[92] This list, which is far from exhaustive, "requires constant vigilance and updating", taking into account new areas of business, developments in technology, and other changes in operating context.[93]

Issues to examine

54. Due diligence processes should critically examine at least applicable local and international laws and standards, including potential conflicts between local laws and human rights; freedom of expression and privacy risks embedded in the company's products and services; strategies to mitigate and prevent these risks; limits on the effectiveness of these strategies given the company's legal, regulatory or operating

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threat of personal sanctions in case of non-compliance". See Telecommunications Industry Dialogue submission, p. 11.

[90] Major telecommunications providers that have developed human rights impact assessments include Telia Company and Telefonica. Ibid., pp. 7-8.

[91] Nokia has embedded an automated feature that flags potential sales for human rights risks in its sales tool. Ibid., p. 7.

[92] European Commission, *ICT Sector Guide on Implementing the UN Guiding Principles on Business and Human Rights* (2013), pp. 32-36.

[93] Michael A. Samway, "Business, human rights and the Internet: a framework for implementation", in *Human Dignity and the Future of Global Institutions*, Mark P. Lagon and Anthony Clark Arend, eds. (Washington, D.C., Georgetown University Press, 2014), p. 308.

environment, and the potential to promote human rights throughout the company's operations."[54]

Internal process and training

55. While dedicated business and human rights professionals within a company are important, due diligence should not be solely their responsibility, but must involve other relevant functional groups within the business. This requires dialogue and collaboration among various business units (such as privacy, law enforcement, government relations, compliance, risk management, product development and operations) and professionals (such as engineers, user-experience researchers, sales teams and business executives).[55] In the privacy context, researchers have found that measures such as "involving and assigning responsibility to senior business unit executives" for privacy management and "embedding staff with privacy protection expertise and personal responsibility for privacy ... into the business units", create an environment conducive to privacy protection.[56] Similar management practices could also ensure business respect for freedom of expression. For small and medium-size enterprises, these considerations might require the entire operation to engage in due diligence activities.[57]

External expertise

56. Given the wide knowledge base required, due diligence processes should draw on external, non-governmental expertise, including local civil society, international human rights organizations, the human rights mechanisms of international and regional organizations, academia and the technical community. Multi-stakeholder fora also provide opportunities for shared learning and mutual accountability. For example, researchers have found that membership in sector- or industry-specific human rights initiatives, such as the Global Network Initiative and the Telecommunications Industry Dialogue, coincides with companies' human rights performance.[58]

Consultation with users and affected rights holders

57. All digital access providers implicate the freedom of expression of end users in one way or another. Accordingly, even companies that are not consumer facing should consult end users as part of their risk assessment process. Such consultation is distinguishable from the broader multi-stakeholder engagement efforts outlined above and contemplates a "two-way dialogue" to "gather specific views or advice from affected stakeholders (or their representatives) that are then taken into account in the company's internal decision-making and implementation processes".[59] For example, vulnerable or marginalized individuals and groups might be consulted while licensing negotiations in high-risk operating environments are ongoing or during the design, testing and rollout of zero rating policies. Meaningful consultation should also involve regular outreach to civil society organizations, which may provide a useful proxy for the needs and interests of end users in particular communities, and might themselves be at greater risk of pressure for their advocacy.

Ongoing dynamic assessments

58. Companies should be quick to adapt due diligence processes to changes in circumstances or operating context. For example, risk assessment should continue after the

[54] Ibid., pp. 310-312, for a more comprehensive overview of relevant topic areas that due diligence processes should cover.

[55] European Commission, *ICT Sector Guide on Implementing the UN Guiding Principles on Business and Human Rights* (2013), p. 36.

[56] Kenneth A. Bamberger and Deirdre K. Mulligan, *Privacy on the Ground: Driving Corporate Behavior in the United States and Europe* (Cambridge, Massachusetts, MIT Press, 2015), p. 177.

[57] European Commission, *ICT Sector Guide on Implementing the UN Guiding Principles on Business and Human Rights* (2013), p. 37.

[58] Ranking Digital Rights submission, p. 5.

[59] European Commission, *ICT Sector Guide on Implementing the UN Guiding Principles on Business and Human Rights* (2013), pp. 37-38.

design phase and at regular intervals throughout the life cycle of the product or service, taking into account factors such as technology and infrastructure changes and associated security vulnerabilities, alterations in consumer behaviour, and modifications of the legal, political and social environment where companies operate.[109]

2. Incorporating human rights safeguards by design

59. As with every major technology development, design and engineering choices reflect public policy considerations, and should be guided by respect for human rights. For example, network slicing, a key 5G technology, could enable mobile providers to manage network traffic more efficiently and cater to the ever-expanding range of consumer needs in the Internet of Things (IoT) era. At the same time, networks could also be "sliced" into fast and slow lanes that prioritize access to some Internet applications over others, potentially interfering with net neutrality. Accordingly, companies should ensure that innovations in network equipment and technology — particularly those with multiple uses — are designed and deployed so as to be consistent with freedom of expression and privacy standards.[110]

60. Companies should assume an active and engaged role in developing expression and privacy enhancing measures. For example, digital security measures that detect and prevent distributed denial-of-service attacks and hacking should be implemented in a manner that targets malicious traffic without compromising legitimate interactions among individuals, organizations and communities. Configuring network equipment to minimize unnecessary information collection about users — given local legal and routing requirements — effectively pre-empts overbroad data requests, since companies cannot turn over information they do not have.[111] Even if user information is logged, meaningful limits on whether and for how long they are retained also restrict the scope of personal and sensitive data available for third party access.

3. Stakeholder engagement

61. Human rights engagement with governments, corporate partners and other stakeholders may prevent or mitigate human rights violations down the line. Companies that deal directly with governments should push for human rights safeguards in operating licences and sales contracts, such as assurances that network equipment will not be accessed or modified without the company's knowledge (which can be for the purpose of facilitating human rights abuses). Timely intervention during litigation (such as amicus filings in cases brought by civil society groups or peer companies against censorship or surveillance laws) and human rights-oriented lobbying in legislative and policymaking processes may also advance legal protections for freedom of expression and privacy.

62. Arrangements with corporate partners should enable all parties to uphold their human rights responsibilities. In particular, such arrangements should be designed to ensure that subsidiaries, joint venture partners, suppliers and distributors will abide by whatever freedom of expression and privacy policies the company has in place. For example, when local operations receive unconventional censorship or surveillance requests, company policy should ensure that these requests are escalated to global management for review.[112] Whistle-blowing mechanisms should be made available to both employees and contractors. To the extent that companies are already in business relationships that raise human rights concerns, they should seek to build leverage over time to prevent or mitigate harm.[113]

63. Companies may also enhance respect for human rights through collaborative action. Such collaboration includes joint outreach and advocacy with peer companies; engagement

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[109] Business and Social Responsibility, "Applying the Guiding Principles on Business and Human Rights to the ICT industry", Version 2.0: Ten lessons learned, A briefing paper (September 2012), p. 9.

[110] ARTICLE 19, "Our 5G future: Light at the end of the tunnel or Internet fast-lane for the elite?" (15 September 2016).

[111] Electronic Frontier Foundation, "User privacy for ISPs and accidental ISPs".

[112] Telecommunications Industry Dialogue submission, pp. 13 and 16.

[113] SHIFT, "Using leverage in business relationships to reduce human rights risks" (New York, November 2013).

with regional or international bodies, including human rights mechanisms and economic institutions, and membership in industry associations and multi-stakeholder initiatives.[107] Regular consultations with users, civil society and affected rights holders can also mobilize public support for company efforts to resist government overreach. Cross-sector collaboration strengthens the normative force of agreed upon human rights best practices and standards, intensifying pressure on both governments and peer companies to comply.

4. Mitigation strategies[108]

64. To the extent that companies handle content regulation and user data requests, specific policies and practices to mitigate the harms of government restrictions may be adopted.

Ensure that requests for content restrictions and customer data are in strict compliance with the law

65. Companies should ensure that all requests for content restriction and customer data comply not only with procedural and legal requirements specified under local law, but also internationally established due process standards.[109] Given the intrusion on human rights, such requests should be authorized by independent and impartial courts or adjudicatory bodies. Furthermore, companies should require that requests be made in writing and present a clear explanation of the legal basis, and the name, title and signature of the authorizing official. Companies should also seek to verify that the relevant official or government entity is authorized to issue this request.[110] These formalities should be requested even if they are not required by law. Additionally, companies should preserve a written record of all communications between them and the requester relating to each request and logs of access to user data when executing the request, provided that such a record does not pose undue privacy risks.[111]

Interpreting the scope of government requests and laws

66. Vague and open-ended government requests and legal frameworks make it difficult for companies to determine whether they are in compliance with local law. However, companies can mitigate this uncertainty by adopting company-wide policies that direct all business units, including local subsidiaries, to resolve any legal ambiguity in favour of respect for freedom of expression, privacy and other human rights. Such policies are based not only on the provider's human rights responsibilities, but also the State's obligation to comply with applicable human rights laws and relevant protections under local law (such as constitutional, criminal procedure and data protection laws).

67. In practice, companies should as far as possible interpret requests in a manner that ensures the least restriction on content and access to customer data. For example, when requests appear overbroad, Global Network Initiative recommends that companies seek clarification on their scope and obtain appropriate modifications.[112]

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[107] Telecommunications Industry Dialogue submission, p. 12; and Global Network Initiative submission, p. 7.

[108] The guidance provided in this section benefited greatly from the Telecommunications Industry Dialogue submission and the Global Network Initiative, "Implementation guidelines for the principles on freedom of expression and privacy".

[109] See, for example, the Manila Principles on Intermediary Liability and the International Principles on the Application of Human Rights to Communications Surveillance, co-authored by a number of non-governmental organizations.

[110] Global Network Initiative, "Implementation guidelines", pp. 5-6; also Telecommunications Industry Dialogue submission, pp. 8-10.

[111] Telecommunications Industry Dialogue submission, pp. 8-9.

[112] Ibid.

Challenge requests and underlying laws

68. Companies have an interest in operating in a legal environment that is human rights compliant, consistent due process and rule of law norms. Companies should explore all legal options for challenging requests that are excessively intrusive — such as requests for shutdowns of entire services or platforms, website takedowns that are clearly targeted at criticism or dissent or customer data requests that cover broadly unspecified users.[111]

69. Like any decision to bring legal proceedings, companies may take into account a range of considerations, such as the "potential beneficial [human rights] impact, the likelihood of success, the severity of the case, cost, the representativeness of the case and whether the case is part of a larger trend".[112] However, companies should assign substantial overall weight to human rights considerations in their decision-making processes and carefully assess both the potential benefits and risks to human rights. For example, companies should be inclined to challenge overbroad requests where there is a reasonable likelihood of success, even if these challenges might be resource intensive; on the other hand, companies might pursue alternative options if a challenge is likely to create adverse precedent or backlash and undermine expression and privacy.

9. Transparency

70. Transparency is a key feature of the digital access industry's responsibility to respect. Information about government activities that require corporate assistance or involvement should be disclosed to the maximum extent allowed by law. Companies should be mindful that such information is primarily used by civil society to challenge human rights abuses in court, register grievances before domestic or international mechanisms on behalf of users or seek alternative means of accountability. Accordingly, such disclosures should be regular and ongoing, and in an accessible format that provides appropriate context.

71. Even if local law limits full transparency, companies should nonetheless disclose all relevant and publishable information. For example, if companies are prohibited from disclosing the origin or basis of a shutdown request, they should nevertheless seek to provide regular updates about the services affected or restored, the steps they are taking to address the issue and explanations after the fact. Innovative transparency measures, such as the publication of aggregate data and the selective withholding of information,[113] also mitigate the impact of gag orders and other non-disclosure laws. Companies should disclose all the local laws with which they comply and, where possible, challenge any law or regulation that prevents or hinders them from being transparent to users and the general public.[114]

72. Companies should disclose their policies and actions that implicate freedom of expression. Relevant disclosures include data retention and use policies, network management practices and the sale and purchase of network filtering and interception technologies.[115] Companies should also disclose information about the frequency, scope and subject matter of due diligence processes and a summary of high-level findings. In general, companies should consult the growing number of resources that study valuable transparency indicators and other transparency best practices. Users, civil society and peer companies should also be consulted on the design and implementation of transparency measures.

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[111] Yael Eisen, "Big Brother's little helpers" (February 2015), p. 40.

[112] Global Network Initiative, "Implementation guidelines".

[113] For example, when "[o]ne Company was required to suspend services, the company did not state that this was the result of technical problems". Telecommunications Industry Dialogue submission, p. 14.

[114] Telecommunications Industry Dialogue, "Information on country legal frameworks pertaining to freedom of expression and privacy in telecommunications" (2013).

[115] Ranking Digital Rights submission.

6. Effective remedies

73. While certain aspects of corporate responsibility have advanced in recent years, remedial steps often seem omitted from the private sector's agenda. Yet remedies are a key pillar of corporate responsibility and should be provided whenever businesses "have caused or contributed to adverse impacts" (see A/HRC/17/31, annex, principle 22). States bear the primary duty to remediate business-related human rights abuses, particularly those they instigate, such as overbroad content restriction, unlawful user data requests and disproportionate surveillance. Yet companies that fail to implement appropriate due diligence measures and other safeguards may also cause or contribute to such abuses. In those situations, companies should "provide for or cooperate in their remediation through legitimate processes" (Ibid.).

74. Remedies may include both financial and non-financial means (Ibid., principle 27). When freedom of expression is impaired, appropriate remedies may include access to grievance mechanisms and information about the violation and guarantees of non-repetition.[116] Users whose accounts have been wrongly suspended may want the satisfaction of being heard and provided with explanations and assurances of non-repetition.[117]

75. Pre-existing policies and mechanisms could also be reformed or strengthened to address violations of freedom of expression. For example, a provider could make improvements to its content restriction policy and the training of its content moderation teams to reduce the likelihood of unfair website takedowns or overbroad content restrictions such as filtering. Customer complaint mechanisms could also be updated to allow users to flag network traffic management practices, commercial filtering classifications and other content restrictions they deem to be unduly restrictive or unfair.

V. Conclusions and recommendations

76. **Individuals depend on digital access to exercise fundamental rights, including freedom of opinion and expression, the right to life and a range of economic, social and cultural rights. They also regularly face obstacles to access: from shutdowns to surveillance. The present report is largely concerned with the obstacles that deny, deter or exclude expression through blunt reliance on digital censorship. The present report has not addressed other serious obstacles — such as the lack of adequate connectivity infrastructure, high costs of access imposed by government, gender inequality, and language barriers — that also may constitute forms of censorship.[118] Much of it therefore focuses on the roles and obligations of States. But States increasingly exercise censorship through the private sector. The report has aimed not only to address the constraints on State action under human rights law but also the principles that private actors should observe in respecting human rights. Key recommendations, already highlighted in the analysis above, are set out below.**

States and the Human Rights Council

77. **The Human Rights Council, in its resolution 32/13, condemned unequivocally measures to intentionally prevent or disrupt access to or dissemination of information online in violation of international human rights law, and called upon all States to refrain from and cease such measures. This condemnation, which is critical to the Council's promotion of human rights online, should be supplemented and specified. Intentional prevention or disruption of access includes any action that shuts down or**

[116] Telecommunications Industry Dialogue submission, p. 17.

[117] Peter Micek and Jeff Landale, "Forgotten pillar: the Telco remedy plan", Access Now (May 2013), p. 6.

[118] Global Commission on Internet Governance submission; Arco Iris Libre de Cuba, Centro de Información Hablemos Press, Centro de Información Legal CubaLex, Mesa de Diálogo de la Juventud Cubana Plataforma Femenina Nuevo País, "Situación del derecho a la libertad de opinión y expresión en Cuba" (Situation of the right to freedom of opinion and expression in Cuba) (July 2016), p. 20.

renders ineffective access to telecommunications networks, mobile services, social media platforms and so forth. Future work of the Council that clarifies the rules that apply to digital access, as outlined in this report, would advance the right to freedom of opinion and expression online.

78. It is also critical for the Council and States to draw the connections between privacy interference and freedom of expression. To be sure, interferences with privacy must be assessed on their own merits under article 17 of the International Covenant on Civil and Political Rights and other norms of human rights law. But certain interferences — such as overbroad requests for user data and third party retention of such data — can have both near- and long-term deterrent effects on expression, and should be avoided as a matter of law and policy. At a minimum, States should ensure that surveillance is authorized by an independent, impartial and competent judicial authority certifying that the request is necessary and proportionate to protect a legitimate aim.

79. The Special Rapporteur is particularly concerned about reports of threats and intimidation of companies, their employees and their equipment and infrastructure. Also, the Council's emphasis on the important role — and need for protection — of the private sector deserves consideration. States should review all activities to obtain network access to ensure that they are lawful, necessary and proportionate, paying particular attention to whether these activities are the least intrusive means for protecting a legitimate aim.

80. The protective role that States may exercise over the private sector can only go so far. They should not be promoting the economic gain of private entities over users' rights to freedom of opinion and expression. Thus, States should prohibit attempts to assign priority to certain types of Internet content or applications over others for payment or other commercial benefits.

81. The intersection of State behaviour and corporate roles in the digital age remains somewhat new for many States. One profitable way forward, at both the international and domestic levels, would involve the development of national action plans on business and human rights in order to establish meaningful avenues for all categories of the digital access industry to identify and address their respective human rights impacts.

Private actors

82. For years now, individuals and companies within the digital access sector have understood that they play an essential role in the vast expansion of access to information and communications services. They are in a business in which the model for success should involve expanding access, efficiencies, diversity and transparency. They should take the principles identified in the present report as tools to strengthen their own roles in advancing users' rights to freedom of expression. In this spirit, in addition to high-level policy commitments to human rights, the industry should allocate appropriate resources towards the fulfilment of these commitments, including due diligence, rights-oriented design and engineering choices, stakeholder engagement, strategies to prevent or mitigate human rights risks, transparency and effective remedies. In doing so, the design and implementation of corporate human rights accountability measures should draw on both internal and external expertise, and ensure meaningful input from customers and other affected rights holders, civil society and the human rights community.

83. This is not to say that private companies do not face pressures. They do. But when States request corporate involvement in censorship or surveillance, companies should seek to prevent or mitigate the adverse human rights impacts of their involvement to the maximum extent allowed by law. In any event, companies should take all necessary and lawful measures to ensure that they do not cause, contribute or become complicit in human rights abuses. Arrangements with corporate partners should be structured to ensure that all parties uphold their human rights

responsibilities. Companies should also seek to build leverage in pre-existing business relationships to prevent or mitigate adverse human rights impacts.